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# ILLINOIS Medical Journal

July 1974 Volume 146 No. 1

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# BLUE SHIELD REPORT



## FOR Illinois Physicians

### New Medical Trustees Elected to Board of Illinois Medical Service

Five medical trustees, including two new members, were elected to the Board of Trustees of Illinois Medical Service at the annual meeting held June 11 at Blue Cross and Blue Shield headquarters in Chicago. Medical trustees reelected to new terms of office were: Dr. Joseph R. Mallory, Mattoon; Dr. V. P. Siegel, East St. Louis; and Dr. Leo P. A. Sweeney, Chicago. The new medical trustees are Dr. George Shimkus of Aurora, and Dr. Thomas W. Samuels, Jr., Decatur.

Dr. Shimkus is board certified in obstetrics and gynecology, his full time specialty. He is a member of the senior staffs of St. Joseph Mercy Hospital and Copley Hospital in Aurora. A member of the American College of Obstetricians and Gynecologists and the American Medical Association, he is a delegate to the Illinois State Medical Society from Kane County.

Dr. Thomas W. Samuels, Jr. is a general surgeon, board certified and in solo practice. He is a staff

member of both Decatur-Macon Hospital and St. Mary's Hospital in Decatur and President of the medical staff of Decatur Memorial Hospital. Dr. Samuels is also a member of the American College of Surgeons and American Medical Association.

Medical trustees in addition to the new members and those reelected are: Dr. H. Close Hesseltine, Chicago; Dr. Franz Steinitz, Chicago; Dr. William De Hollander, Springfield; Dr. Alexander Ruggie, Skokie; and Dr. Robert Stepto, Chicago.

Ten medical trustees and nine public trustees serve on the Blue Shield Board. Public trustees include: Henry B. Anderson, Chicago; Howard Buila, Minonk; Dr. Frederick L. Eihl, Moline; Dr. O. Kenneth Johnson, Chicago; Emil J. Koe, Park Ridge; George E. Tapling, Chicago; Robert Agnes, Bensenville; Weir C. Swanson, Arlington Heights; and Mathew P. Cicero, Rockford.

Officers of the corporation are: Dr. H. Close Hesseltine, Chairman of the Board; Dr. V. P. Siegel, Vice Chairman; Mr. Robert M. Redinger, President; Dr. Alexander Ruggie, Secretary; and Mr. George E. Tapling, Treasurer.

### Highlights of Annual Report . . .

#### Record Levels of Corporate Operations, Service Improvements for '74 Emphasized

Record operating levels were achieved by the Illinois Blue Cross and Blue Shield Plans in 1973, Robert M. Redinger, Chief Executive Officer, stated in his message in the 1973 annual corporate report published recently. Commenting on operations, he noted that approximately 4½ million claims were paid by the Plans under both private and government programs during the year, representing an 11 percent increase over 1972, with the total dollar volume of business approaching \$1 billion.

Other highlights of operations and programs cited were:

(1) Membership in the Illinois Blue Cross Plan reached a total of 3.2 million persons in 1973, and Blue Shield membership increased 9 percent to a high of 2.9 million.

(2) Programs in which the Plans are primarily involved in the health care delivery field include: Containment of health care costs; development of Health Maintenance Organizations; introduction of new coverages; cooperation with consumer interests and community affairs.

(3) Because of the tremendous growth in the number of insured persons and the changes occurring in health care delivery in the past few years, considerable stress has been placed on the Plan's internal operations that require attention. Service improvement is, therefore, the number one objective of both corporations in 1974.

"By determining where service improvements are needed and how these improvements can best be achieved, we can assure our members of progress in this area in 1974", Mr. Redinger emphasized.

## ASK BLUE SHIELD . . . ABOUT MEDICARE

### ACCEPTING ASSIGNMENT OF MEDICARE BENEFITS

When a physician and his patient agree to the assignment method of billing for Medicare services, the patient conveys his right to payment of benefits to the physician. Under the assignment of benefits the physician agrees to accept the reasonable charge as determined by Part B Medicare as payment in full for services or items he furnishes, and that he will not bill the patient for any charges disallowed as "more than the allowable charge".

The patient is responsible for 20% of the allowable charges (20% coinsurance), any amount applied to the Part B deductible, and any charge for services disallowed as non-covered. The Part B carrier will pay 80% of the reasonable charge over and above the \$60 deductible.

Each year a new Part B deductible must be met by the patient. Effective January 1, 1973 the amount of the deductible was increased to \$60. Even though a person is not eligible for Medicare for the entire year, the full deductible must be met. A "carry-over" provision in the regulations, however, applies to covered expenses incurred in the months of October, November and December. Any covered expenses incurred in those months which are applied to the deductible for that year will also be applied toward the deductible for the following year.

If a patient, for example, had no medical expenses for the year 1973 until the month of October and then incurred covered expenses of \$60 during the next three months, these expenses will satisfy the deductible for 1973 and 1974. As another example, a patient may incur expenses of \$20 prior to October and another \$40 in November and December. The \$40 will be applied toward the 1974 deductible, as well as the remaining 1973 deductible.

The "carry-over" rule was established to help the beneficiary who might otherwise have to meet the entire deductible twice in a comparatively short period of time.

Before payment can be made, the claim form, SSA 1490, Request for Medicare Payment must be completed, including the signature of the patient and the physician on every assignment claim. Item #12 on the claim form (Assignment of patient's bill) must show whether the physician and patient agreed to the assignment. The box "I accept assignment" must be checked, otherwise payment will be made to the patient.

The patient's signature must appear on the SSA 1490 Request for Medicare Payment form except under the following circumstances:

(1) When the patient is a Public Aid recipient he is not required to sign the form. The Public Aid number of the patient is noted on line 5, and on the patient's signature line the wording "Public Aid Patient" is either stamped or written by the physician or his office assistant.

(2) When a patient is unable to sign the claim form because of a mental or physical condition, the patient's name is shown on line 6 of the form, followed by the word "by" and the signature and address of the relative or approved representative explaining his relationship to the patient. A statement is also needed explaining why the patient was unable to sign the request.

(3) If a person cannot write his name, he may sign with the mark (X) on the signature line, but the name and address of a witness must also appear on the line.

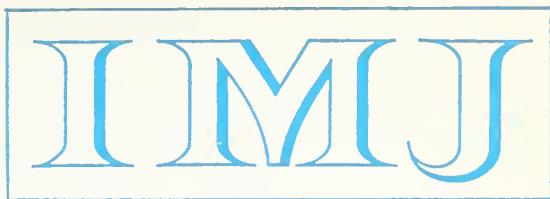
(4) When a patient is deceased and the physician accepts assignment, line 6 may be completed by the physician indicating "Patient is deceased".

(5) A physician treating a patient over an extended period, who agrees to accept assignment, may obtain the patient's consent to assignment of unpaid bills for an anticipated period of treatment by having the patient sign a statement as follows:

"I request that payment under the Medical Insurance Program be made directly to Dr. \_\_\_\_\_ on any unpaid bills for the services furnished me by that physician during the period \_\_\_\_\_ to \_\_\_\_\_. The period should extend no longer than the close of the calendar year, and the statement should be attached to the original claim and be submitted in the usual manner. On subsequent claims, the physician should indicate: "This is a continuation of a course of treatment for which the patient's assignment was previously obtained." This statement should appear in the signature box.

When the physician accepts assignment for a recipient of Public Aid the SSA 1490 form should be completed in triplicate. Send the first copy of the SSA 1490 to your Medicare carrier, and the second copy to the Illinois Department of Public Aid, Medical Administration, 425 South Fourth Street, Springfield, Illinois, 62762. The third copy should be kept in your files.

Medicare will allow 80 percent of the reasonable charge after the annual \$60 Part B deductible has been satisfied. A copy of the Explanation of Medicare Benefits (EOMB) indicating payment or non-payment will be sent to the Public Aid office. Public Aid will match this EOMB with their copy of the SSA 1490 and adjudicate the claim to make payment under the provision of the Public Aid law.



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(Cover by Jane E. Bushwaller)

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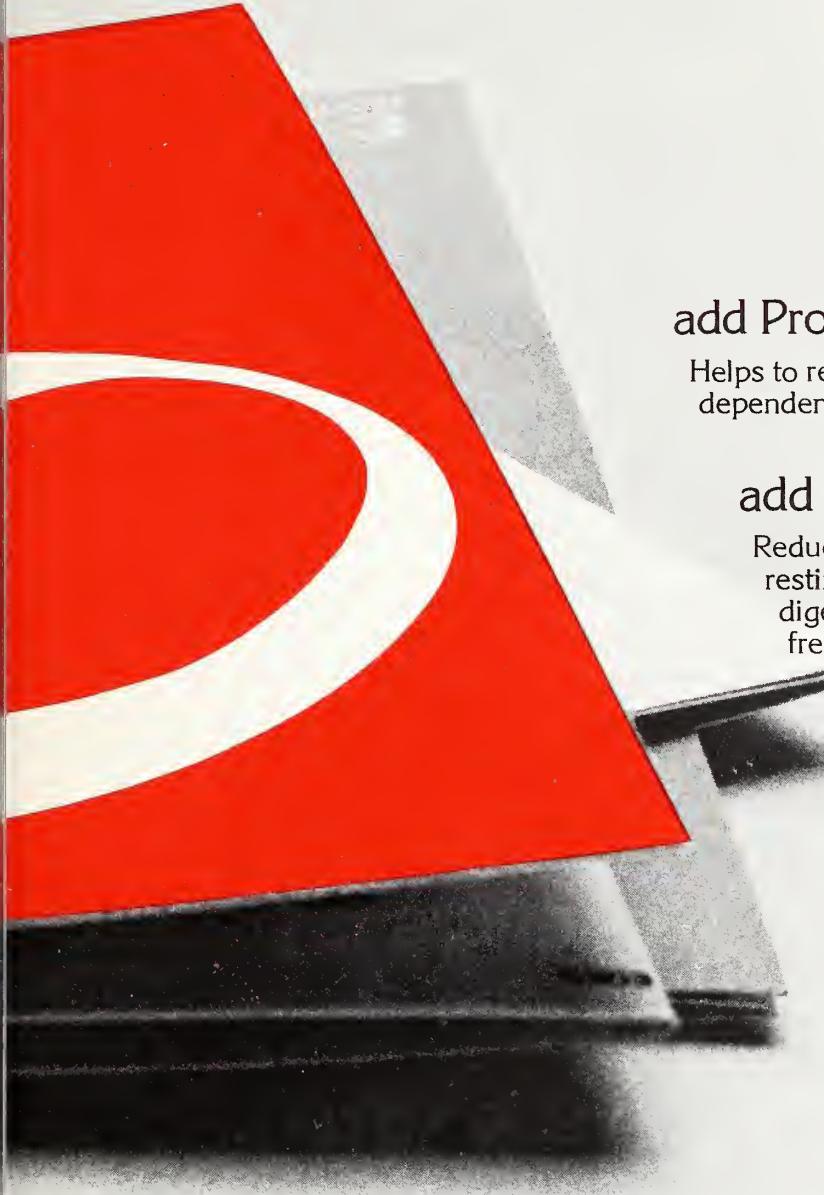
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\*Fordtran, J. S., and Colluys, J. A. H.: Antacid Pharmacology in Duodenal Ulcer: Effect of Antacids on Postcibal Gastric Acidity and Peptic Activity, *New England J. Med.* 274:921-927 (April 28) 1966.

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## *President's Page*

# A Challenge— Not An Invitation

All too frequently I hear the complaint that the state medical society "does not represent me." This tune is sung by physicians who have made no effort to be represented. Often they have not participated nor made the least effort to become involved in the affairs of their county society or ISMS. They have permitted their "representatives" to be chosen for them by others.

Also heard—all too often—is the complaint that a small clique runs the show. If true, this is so only because the body politic—the grass roots—permits this to happen by abdicating its rights—especially the electoral franchise.

The privilege of authoring this page has befallen me not because I had the right "school tie" nor because I was a member of the "power bloc"—I have neither of these qualifications. I hold my office because within the "halls of medicine" I have dared to address the issues and to speak my piece.

In my previous message on this page, I invited the membership to make known to the House Select Committee its views on the problems besetting the society, and to offer any suggestions on its governance, organization and operations. I pointed out that this is your opportunity to participate in restructuring ISMS and eliminating its troubles.

I have received some disconcerting feedback from this invitation. There are physicians who predict that the Select Committee will lay a sterile egg. To them I suggest that the Committee can fail only if you, the members of ISMS, let it fail. The recommendations of this committee will be reported at the House of Delegates in April, 1975. What those recommendations will be depends upon you.

**The action of your delegates will determine the success or failure of this monumental effort. If you ordain the needed changes, your delegates dare not ignore you.**

A handwritten signature in blue ink that reads "J. M. Ingalls, M.D."

*Submit comments to Committee Chairman and ISMS President-Elect J. M. Ingalls, M.D.,  
502 Shaw Avenue, Paris, Ill. 61944.*

# **Guidelines in the Selection of A Weight Control Program or Product**

*At its recent meeting, the ISMS Board of Trustees approved the "Guidelines In the Selection of A Weight Control Program or Product." These "Guidelines" were produced to inform patients what to look for when selecting a weight reduction regimen. Copies of the "Guidelines" are available for distribution to patients or for display in physicians offices; contact: ISMS headquarters, 360 N. Michigan Ave., Chicago, 60601.*

1. CONSULT a physician to make sure the program or product is safe for you. Most diets, drugs, exercises, and products are designed for people in good physical condition. It is imperative to have a doctor's approval BEFORE BEGINNING potentially dangerous weight control procedures or products.
2. BE WARY of deceptive advertising. NO SINGLE ITEM CAN OFFER GUARANTEED RESULTS.
3. KNOW what "medical supervision" means. Programs which do not have a physician, licensed to practice medicine in all of its branches, on the premises at all times, are not medically supervised.
4. SEE a physician regularly while participating in a weight control program or using a reducing product. Such check-ups will insure that the program or item is not deleterious to your health.
5. FIND out if drugs are to be used in a weight reduction program. If so, *medical supervision* is essential.
6. BEWARE of any drug used for weight control which has not been approved by your physician. Drugs like Human Chorionic

Gonadotropin (H.C.G.) are considered experimental, and are not F.D.A. approved for weight control. To determine the status of a particular drug, consult your physician.

7. CHECK diet regimens with a physician or local health department to insure that they meet the nutritional requirements necessary to maintain good health.
8. REMEMBER, exercise should accompany any weight loss for increasing energy output and toning tissues and muscles. However, exercise alone is inadequate for losing weight, and could be harmful if not properly supervised or structured to meet your limitations.
9. BE WARY of special drugs, fad diets, or mechanical reducers which guarantee dramatic losses in weight. Any sudden change in weight is potentially hazardous. Body wrappings, in particular, should be discouraged. These can be dangerous, and may cause severe circulation ailments.
10. REMEMBER, the "secret" of weight control is a "RETRAINING" of eating habits. This will help maintain the weight you lose. Any program which fails to do this is inadequate. ◀



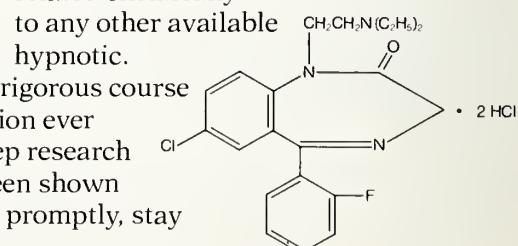
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# **Abstracts of Board Actions**

**June 1-2, 1974**

**Chicago**

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.*

## **1974 Annual Meeting**

The Board of Trustees agreed that ISMS would underwrite up to \$11,500 of deficit incurred by the scientific program planned in conjunction with the 1975 Midwest Clinical Conference and the annual meeting of ISMS. The agreement is contingent upon a uniform accounting system being developed by the treasurers of ISMS and the Chicago Medical Society. The subsidy was necessitated by the decision to discontinue technical and scientific exhibits.

## **TAP Institute**

The Executive Committee was authorized to decide if ISMS should co-sponsor a "Trustee-Administrator-Physician" TAP Institute to be conducted in October by the Joint Commission of Accreditation Hospitals. If the Executive Committee judges the institute's program content to be contrary to ISMS policy, participation will be declined.

## **Outlook Sanatorium**

The Board approved and forwarded to the Champaign County Medical Society a report presented by an ISMS physician committee following its inspection of the Outlook Sanatorium in Champaign. The report refuted adverse findings of the Illinois Department of Public Health Tuberculosis Advisory Committee. The Board authorized the Champaign Medical Society to release the ISMS report to the press.

## **Benevolence Fund**

All applicants for benevolence and annual renewals of aid will be screened by the appropriate district trustee, who may call upon the county medical society or its auxiliary for assistance in checking eligibility.

## **Amendments to Emergency Medical Treatment Act**

In a followup to previous action, the Board approved ISMS introduction of amendments to the Emergency Medical Treatment Act in the current session of the legislature.

## **National Blood Program**

Endorsement of the American Blood Commission Plan was approved by the Board and the Department of Health, Education and Welfare was notified.

## **Resolution on Family Practice**

The Board withheld approval of a resolution asking the General Assembly to require medical schools to report their progress in developing and expanding family practice departments. Further action will depend on the position taken by the Illinois Academy of Family Physicians on this matter.

## **PSRO Ad Campaign**

Following a progress report on the campaign to inform the public of the deleterious effects of PSRO, the Board directed that a sample "Confidentiality" envelope stuffer be mailed to all ISMS members with an order blank on which additional copies may be requested.

In a related action, the Board instructed the AMA delegation to support in the

(Continued on page 58)

# Kefzol®

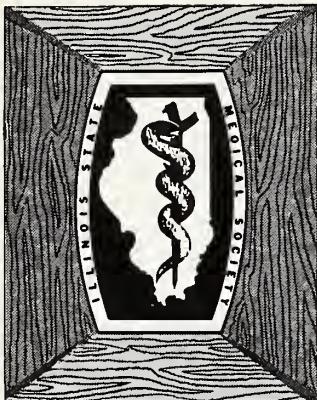
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# IMJ

*Illinois Medical Journal*

Vol. 146, No. 1, July, 1974

## Swimming Instruction for Pre-School Children

BY EUGENE F. DIAMOND, M.D./MAYWOOD

Accidents are the leading cause of death between one and four years of age and drowning is the number three cause of fatal accidents in this age group. About 15% of all fatal accidents between ages one and four years are due to drowning. The circumstances of these drownings are shown in Figures 1 - 4.

The American Academy of Pediatrics is, therefore, concerned about the 2,500 deaths each year due to drowning, including the over 800 infants under four years of age who drown. We do not wish to delay the learning of water skills for so long as to be teaching swimming only to a few survivors.

On the other hand, we are aware that one of the unfortunate characteristics of this modern era is excessive adult intrusion into juvenile recreation. Particularly in suburbia, inappropriate pressures tend to be brought on immature children to develop all kinds of skills at a rate not in keeping with orderly process of neuro-

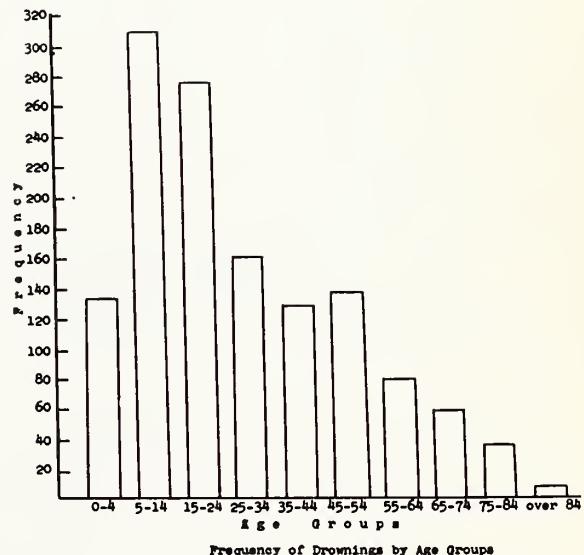


Figure 1

muscular development and maturation. The laudable efforts of Little League baseball, Pop Warner football, and pee-wee hockey to broaden the base of juvenile sports participation are often frustrated, if not negated, by over-zealous parents looking for vicarious gratification.

It was against this background of dilemma and mixed emotions that the Joint Committee on Physical Fitness, Recreation and Sports went about the development of an official statement



EUGENE F. DIAMOND, M.D., is Professor of Clinical Pediatrics at Loyola University Stritch School of Medicine. Dr. Diamond served residency programs in internal medicine and pediatrics. He is the author of numerous scientific publications. An active member of the American Academy of Pediatrics, Dr. Diamond is presently the Chairman of their Joint Committee on Physical Fitness.

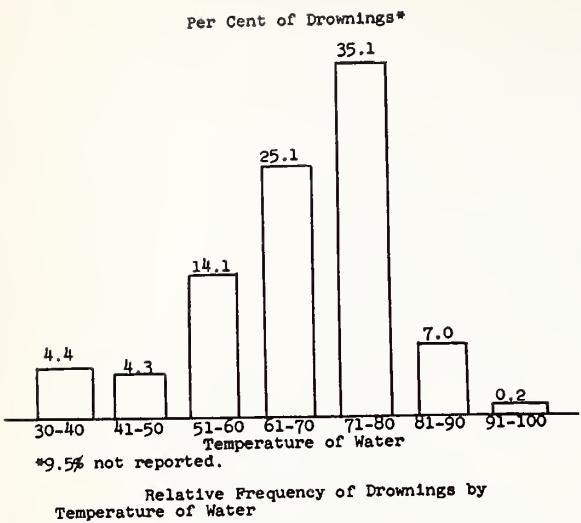


Figure 2

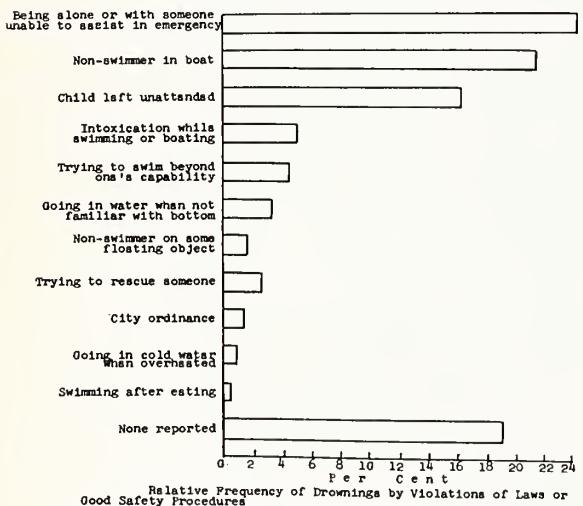


Figure 3

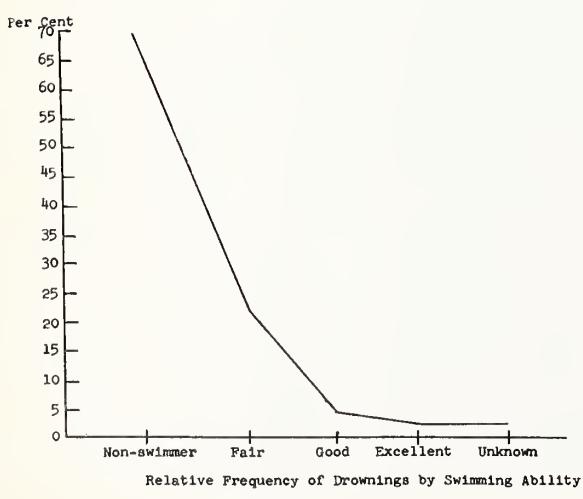


Figure 4

on Swimming Instruction for Infants. The text of the statement is as follows:

#### Swimming Instruction For Infants

Children less than three years old are most vulnerable to drowning, and organized attempts to reduce the toll are indicated.

Swimming instruction, heretofore, has concentrated on school age children. Recent efforts have been focused on teaching young children to swim, even during the first year of life. It may be possible to teach very young infants to swim and keep their heads above water, but it is questionable whether or not an infant can truly be taught water safety and proper reaction to an emergency. Parents can develop a false sense of security if they know that their young infant can swim a few strokes.

Additional problems are associated with admission of infants to public pools. Incontinent infants in pools certainly pose an aesthetic problem, and it is difficult to maintain the effectiveness of chlorination. In addition, infants with age-specific immunity handicaps would be subject to significant exposures to enteroviruses, adenoviruses, and other potentially dangerous microorganisms in dosages not likely to be found under controlled home conditions.

Considerations involved in the use of swimming as a form of "patterning" are not of sufficiently established benefit to be weighed as factors in favor of early pool training.

It is not recommended that large-scale programs be undertaken to teach swimming to children under the age of three years.

However, it is recommended that efforts to reduce the incidence of drowning in children under three years of age should concentrate on three measures of proven effectiveness:

1. More adequate fencing and other protective measures to exclude infants from pool areas or areas of excavation.
2. The assurance of constant parental or other adult supervision for all non-swimmers in swimming areas.
3. The use of flotation jackets for all non-swimmers close to bodies of water or in boats.

The Academy of Pediatrics is represented on the Council for National Cooperation in Aquatics. At the November, 1971, meeting of the council, our representative with representatives from YWCA, YMCA, American Red Cross, Boys Clubs of America, The United States Office of Education and representatives from The Schools of Physical Education at Purdue and Yale Universities developed the following statement on the subject of pre-school swimming:

Because certain considerations affecting a child's learning and safety require a degree of development not attained by most children before they are three years old, the Council for National Cooperation in Aquatics recommends that the

minimum age for organized swimming instruction be set at age three. It is imperative that parents be made to realize that even though pre-schoolers may learn to swim, no young child, particularly the pre-schooler, can ever be considered "water safe" and must be carefully supervised when in or around water.

### *Guiding Principles*

For organized pre-school swimming programs, CNCA recommends the following guiding principles:

1. Pertinent health information about pre-existing conditions which would affect a child's ability to participate in the activities should be obtained from the parents before a child is accepted into an organized swimming program.
2. Swimming instruction of pre-school children requires a staff of sufficient number to provide a very low ratio of instructors or aides to children. This requirement may be met by using parents and other volunteer aides working directly under professionally competent leaders.
3. Parents involvement in and understanding of the program is essential. Their orientation should include:
  - (a) Complete understanding of program objectives.
  - (b) A clear picture of the skills that can be developed by the young child as well as the realization of his limitations.
  - (c) Their responsibility in supplementing and enhancing the role of the instructor.
  - (d) Accepting their role in the supervision of the pre-school child any time the child is near water.
4. Orientation of the child to facilitate adjustment to the total physical environment should precede the first class experience.
5. The learning of skills of the young child is directly related to active participation in the instructional programs and to frequency of practice; the retention of skills is dependent upon reinforcement through frequent opportunity to participate.
6. The water temperature usually found in multiple-use indoor pools (in the range of 78-82°) is acceptable for most children in this age group, provided that the teaching procedures include continuing vigorous activity.
7. Suitable flotation devices when used in a controlled teaching situation help promote safer participation and can enhance learning.

It is entirely appropriate to begin instructional programs after infancy in the three-seven year age group. Our main reluctance is to recommend organized programs for those under three years of age, and we recognize that individuals will still wish to undertake instructions for their own infants. We recognize that there is some disagreement as to whether or not it is possible to accommodate chlorination to the increased contamination incurred by allowing incontinent

infants to swim. The increased susceptibility of infants to enterovirus and adenovirus infection is a real problem and not reducible by any program of pool antisepsis. The alleged benefits of infant swimming programs as "patterning" or "sensitivity" sessions are highly controversial. If there are benefits, they are as readily attainable on land as in water.

The American Red Cross estimates that there are 90 million non-swimmers in this country. Efforts to reduce this number are entirely appropriate to the prevention of death by drowning. Swimming instruction programs will be most successful, however, when they take realistic account of the realities of growth and development.

The techniques of swimming instructions are beyond the scope of this presentation. It is important to emphasize, however, that all rules of child guidance are not suspended by the desire to teach a child to swim. The initial skills usually taught are breath control, prone float, and dog paddle. When dealing with younger children, it is probably true that one is likely to encounter a smaller percentage of students who have a pathological fear of water. It also is probably true that fears of water are not always reconciled by persuasion or logical explanation of hazards and safeguards. There is, however, an inclination to circumvent the need for explanation and education in the younger age groups. Because of the instructor's obvious superiority in size and strength, there is a temptation to resort to compulsion and intimidation. All of us have seen the dramatic change which can come over a young child through even a brief successful experience in the water. In order to bring about this important initial achievement, it may be necessary to resort to firmness, pressure and even coercion at times as long as the pervading background is one of gentleness and sympathy. All programs of swimming instruction which include, as basic instructional techniques, throwing children into the water or holding children under water will be viewed askance by pediatricians. Those who contend that such techniques are necessary and innocuous will have to support their view points with prospective studies and objective psychological data. Retrospective claims, short-term observations, and disclaimers based on prestige and experience will not necessarily be admissible. Neither will it be possible to justify every technique of instruction on the basis of overall success of a program in teaching children how to swim.

*(Continued on page 61)*

# The Cholesterol Hypothesis and the Coronary Primary Prevention Trial

BY PHILIP A. HABAK, M.D., HELMUT G. SCHROTT, M.D., AND WILLIAM E. CONNOR, M.D./IOWA CITY, IA.

**H**eart disease is presently the leading cause of death in the United States, ranking well above cancer, accidents and infections. In 1967, 54.1% of all deaths were due to cardiovascular disease and approximately 626,000 deaths from atherosclerotic and degenerative heart disease were reported during the same year.<sup>1</sup> In men between 40-59 years of age, the death rate is even greater, reaching about 8 per 1000 per year.

Among the various coronary risk factors, the level of serum cholesterol has attracted much interest recently. The Framingham heart study<sup>2</sup> and other studies have clearly identified the level of serum cholesterol as a major risk factor for atherosclerotic coronary heart disease. Furthermore, the relationship between an elevated serum cholesterol and atherosclerosis is supported by the discovery that in several species of animals atherosclerotic lesions can be produced by high cholesterol, high saturated fat diets<sup>3,4</sup> and by the experiments of Taylor et al<sup>5</sup> who were able to induce fatal myocardial infarctions in Rhesus monkeys fed a high cholesterol diet.

More recently, Armstrong, et al<sup>6</sup> reported that regression of arterial plaques occurred in monkeys when a low cholesterol diet was subsequently introduced suggesting that at least in that species, the process may be reversible. In man, however, regression of the disease has not been observed and whether measures to reduce serum cholesterol are effective in preventing coronary heart disease is still open to question. Most studies of the efficacy of dietary or drug treatment were secondary prevention trials in that patients with documented coronary heart disease were entered into treatment programs and observed for varying lengths of time. For example, the Oslo diet heart study included 412 men one to two years post myocardial infarction who were randomly allocated into diet treatment and

control groups.<sup>7</sup> After five years, the diet treatment group had significantly fewer myocardial infarctions. However, the difference in the death rate was not statistically significant. In England, a similar study involved 395 persons who were divided into diet treatment and control groups.<sup>9</sup> The treatment group had fewer coronary events but the difference was not statistically significant. Actually, the treatment group had slightly more cardiovascular deaths. Diet studies such as these are not convincing because of small numbers, reliance on soft end points, and use of subjects with advanced coronary heart disease. If high risk groups had been selected, i.e. hypercholesterolemic men, and entered into the different treatment groups before the development of coronary heart disease, the results might have been different.

The Coronary Primary Prevention Trial is well under way in several Lipid Research Clinics throughout the country. It is a centrally co-ordinated, randomized, double blind primary prevention study using patients with type II hyperlipoproteinemia (hypercholesterolemia) and designed to substantiate the lipid hypothesis and the efficacy of intervention. The patients admitted into the study will have an elevated serum cholesterol level mainly secondary to an increase in the concentration of low density or beta-lipoproteins. These lipoproteins contain a greater proportion of cholesterol than the other lipoprotein fractions and there is a high correlation between their concentration and the incidence of atherosomatous disease both in animals and in man.<sup>10</sup> Beta-lipoproteins are synthesized by the liver and gut and their serum concentration depends on the balance between synthesis and degradation. The role of dietary cholesterol, fat content and the ratio between polyunsaturated and saturated fats in the genesis of atherosclerotic vascular disease may be related to alterations in the concentration of the beta-lipoproteins in the plasma.

Physicians in western Illinois, within a 50 mile radius from the Quad-Cities will have the oppor-

The authors are from the Lipid Research Clinic, Cardiovascular Division of Department of Internal Medicine at The University of Iowa College of Medicine, Iowa City, Ia.

tunity to play a substantial role in this unique and important cooperative study. Thus, the selection and referral of patients to the Lipid Research Clinic in Iowa City is primarily dependent on the active participation of interested physicians in practice in their respective communities.

### The Lipid Research Clinics

The Lipid Metabolism Branch of the National Heart and Lung Institute was created in December, 1970. A network of continent-wide Lipid Research Clinics located in 12 universities in the United States and Canada was established. Their major objectives included the performance of studies on the prevalence and natural history of the hyperlipoproteinemias and a primary prevention trial on patients with hypercholesterolemia.

The University of Iowa is among the institutions which were approved to participate in this major research goal and to host a Lipid Research Clinic. The Iowa Lipid Research Clinic staff will offer consultation and assistance to all physicians encountering management problems in patients with disorders of lipid metabolism. The Lipid Core Laboratory of the Clinic has been standardized according to the Lipid Standardization Laboratory of the Communicable Disease Center in Atlanta, Ga. The University of Iowa Lipid Laboratory will be available as a reference for the standardization of other laboratories which perform various blood lipid studies and would provide assistance to any clinical laboratory wishing information regarding specific technical problems in the lipid field. The protocol for the primary prevention trial, also known as the Lipid Research Clinics Type II Coronary Primary Prevention Trial, was approved by the Lipid Research Clinics Directorate in November, 1972.

### The Primary Prevention Trial Protocol<sup>11</sup>

#### I. Patient Population

A minimum of 300 men per clinic, 35-59 years of age, will be enrolled in the project. These men will have hypercholesterolemia (type II hyperlipoproteinemia) and thus are coronary prone individuals. Type II hyperlipoproteinemia is characterized by elevated levels of serum cholesterol, beta-lipoproteins and a clear fasting serum. It is sometimes associated with tendon nodules (xanthoma tendinosa), xanthelasma, and (less frequently) skin xanthomas of the tuberous type. Frequently it is an hereditary disorder, trans-

mitted as a simple Mendelian dominant trait, but may also occur in part secondary to a cholesterol rich diet, hypothyroidism, nephrosis, dysproteinemias or obstructive liver disease. The patients referred to the prevention study should be healthy men having no angina pectoris, history of a myocardial infarction, coronary insufficiency or heart failure as well as severe hypertension. Patients with diabetes mellitus, other endocrine disorders and diseases limiting life expectancy to less than five years also are not eligible for the study. In addition, they should not be receiving any of the following medications: estrogens or androgens, thyroid, corticosteroids, anticoagulants, quinidine, procainamide or digitalis.

#### II. Recruitment

The enrollment of 300 men with type II hyperlipoproteinemia between the ages of 35 and 59 years into the study will require the screening of a much larger population that may amount to 10,000 subjects. Western Illinois and Eastern Iowa physicians will play a central role in identifying and referring these patients. Candidates for this program should have cholesterol levels greater than 285 mg%. We would like to stress the fact that the referring physician remains the primary physician for the patient, with the Lipid Research Clinic staff serving only as consultants in the special area. The referring physician will be furnished a copy of the initial medical evaluation, the cardiovascular workup and the results of all screening tests as well as reports of subsequent examinations.

It also should be mentioned that all patients referred to the study stand to benefit. These are some of the advantages to the participants: 1) general medical workup; 2) lipid and cardiovascular workup; 3) all patients will receive dietary counseling; and 4) there are no costs to the patient. Furthermore, since there is a familial preponderance of hypercholesterolemia, family members including siblings and children also may indirectly benefit.

#### III. Preliminary Evaluation

All patients will undergo an initial evaluation which will be spread over five monthly visits. The study will be explained to the patients individually and their consent will be obtained. The initial screening process will include testing for diabetes mellitus and for disorders of the thyroid, liver and kidneys as well as a complete cardiovascular evaluation. Thus, in addition to a complete history and physical examination, some of the visits will include a blood lipid profile, blood counts and blood chemistry, an elec-

trocardiogram as well as a treadmill exercise test. All laboratory results obtained in the initial period will be communicated to the patient's primary physician and only those individuals who successfully complete this screening program, the most coronary prone men, will be eligible for the treatment phase of the study.

#### *IV. The Treatment Phase of the Study*

At Visit 2, the patients will be placed on a cholesterol modified diet. This diet is best described as a prudent diet. It is expected to produce some reduction in the serum cholesterol level. At Visit 5, following completion of the preliminary workup, the patient is randomly allocated to one of two treatment groups: the diet and placebo group or the diet and Cholestyramine group. Cholestyramine is a bile acid sequestrant which is expected to achieve an average reduction in serum cholesterol of about 20%. The drug has been used at the University of Iowa and elsewhere for eight years and has been found to be remarkably free of serious side effects. Cholestyramine was approved by the Food and Drug Administration on August 6, 1973.

If we can conclusively establish that lowering the cholesterol level can prevent premature coronary heart disease, then the time and effort expended to vigorously treat high risk patients will be worthwhile. Because such a study is important from a personal and family point of view as well as from a national standpoint, it is necessary to eliminate bias in the conduct of the investigation which might mitigate against the results. Accordingly, neither the patient nor the physician seeing him in the Lipid Research Clinic will know whether drug or placebo is being dispensed. The patient's lipid levels in the treatment phase are mailed to a Central Patient Registry located in Chapel Hill, North Carolina, and will not be known to either the clinic physicians or the patient's primary physician. The patient's physician also will be requested to refrain from ordering blood cholesterol determinations on patients enrolled in the project to avoid unblinding the study. Should it become important for medical care, the information on a certain patient's lipid studies or treatment can be obtained from the local Lipid Research Clinic.

#### *V. Follow-Up Phase*

During the follow-up period, which is expected to last five to seven years, the subjects will be seen in the Lipid Research Clinic at two month intervals for blood lipid determinations and screening for side effects. A more extensive outpatient evaluation will be performed every six months and a stress electrocardiogram will be

obtained once a year.

#### *VI. End Points*

Primary end points in the study are a definite non-fatal myocardial infarction or a definite atherosclerotic heart disease death (fatal myocardial infarction, sudden death). Other response variables include different forms of arterial atherosclerotic disease; arterial peripheral vascular disease and cerebral vascular disease are considered here.

#### *VII. Safety and Data Monitoring Board*

A Safety and Data Monitoring Board will review all the data accumulated during the study. The board may recommend changes in the design of the study or its premature termination on the basis of toxicity data or whenever a significant difference in end points is found between the control and the treated group. At the end of the follow-up period, based on the findings and conclusions gathered, appropriate treatment of patients in the study will be recommended.

### **How to Refer Patients**

Interested physicians can refer potential candidates for this program by writing or calling the Iowa Lipid Research Clinic at S-228 Westlawn, Iowa City, Iowa 52242; telephone number 319-356-2095. Physicians in Southern Illinois may wish to refer their patients to Dr. Gustav Schonfeld or Dr. Joseph Witztum at the St. Louis Lipid Research Clinic, Washington University School of Medicine, Box 8046, 4566 Scott Avenue, St. Louis, Missouri 63130; telephone number 314-454-3461. ▀

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*(Continued on page 61)*

# Rupture of the Heart

## Report of a Case With One Week Survival

BY ARNALDO G. CARVALHO, M.D., F.A.C.C./SPRINGFIELD

Because of the marked progress made during the last few years in the prompt recognition and treatment of arrhythmias in patients with acute myocardial infarction, most deaths in coronary care units today are the result of congestive heart failure, shock or rupture of the heart.

The incidence of cardiac rupture is between 4 and 13% of fatal cases.<sup>1</sup> Recently attention has been focused on certain characteristic electrocardiographic patterns that occur in cardiac rupture. Mogensen et al<sup>2</sup> reported seven patients with rupture and tamponade whose electrocardiograms were monitored during the terminal event: all had abrupt onset of bradycardia, initially of sinus origin and then nodal. Meurs et al<sup>3</sup> reported 8 patients who had slowing of sinus rhythm followed by nodal rhythm.

The present report deals with the electrocardiographic findings in a patient with rupture of the heart; the case was unusual because the patient survived for several days following the initial manifestations of cardiac rupture.

### Case Report

A 67-year-old female, was admitted to Saint Johns Hospital on 9/9/72 with chest pain radiating to the left arm. She gave a history of angina for 8-10 years with crescendo angina for one month prior to admission. Chest pain recurred over the next several days requiring the administration of opiates. At 4 p.m. of 9/12 she complained of chest pain on inspiration. At 9:05 a.m. of 9/13, while she was sitting in bed and a physician was listening to her lungs, she suddenly became unconscious; no blood pressure or pulse could be obtained. Monitor strips at that time and during the next 40 minutes showed alternating A-V dissociation, sinus tachycardia and A-V block. (Fig. 1)

Resuscitative measures including an attempt at pericardiocentesis were carried out and circulation was restored. Over the next several hours administration of levaterenol was necessary in order to maintain the blood pressure. Her condition continued to improve, however, and administration of levaterenol was discontinued at 9 p.m.



ARNALDO GOMES CARVALHO, M.D., is Chief, Cardio-Vascular Department, St. John's Hospital, Springfield and is Clinical Associate Professor, Southern Illinois University School of Medicine. Dr. Carvalho is a Fellow, American College of Cardiology and certified by the American Board of Cardiovascular Diseases.

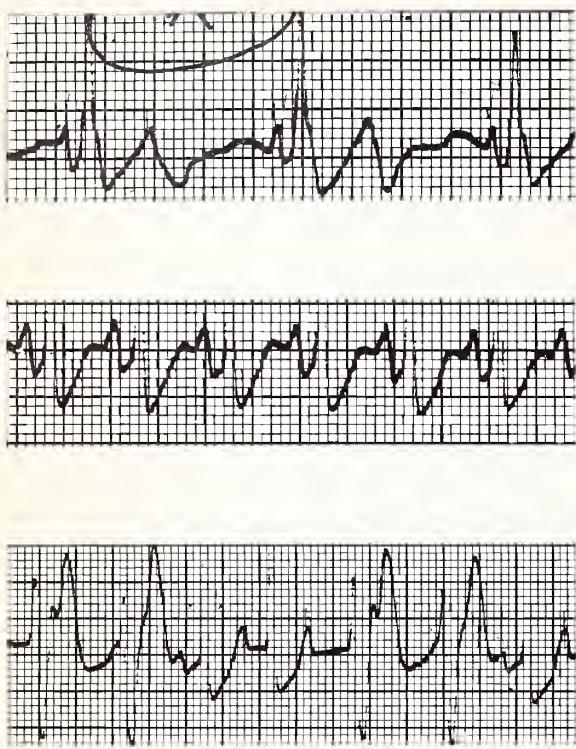
During the next several days she had ventricular ectopic beats which were controlled with Lidocaine. On 9/19 at 9:15 p.m. she had ventricular tachycardia followed by bradycardia and cardiac arrest. (Fig. 2)

Post-mortem examination showed the pericardial sac to be distended by 250 cc of semi-clotted blood, mostly adherent to the inferior surface of the heart. The heart weighed 320 gm. An extensive transmural myocardial infarction involved most of the inferior left ventricular wall. At approximately the mid-point of the infarcted area a probe patent small area of dissection through the necrotic muscle was demonstrable; adherent clots were found around and external to this zone.

### Discussion

This case illustrates some of the features commonly associated with cardiac rupture, which is more common in women<sup>4</sup> (6.9% of fatal myocardial infarction vs. 3.8% in men) and usually occurs in the seventh decade or later.<sup>1</sup> Hypertension is present in a large percentage of patients.

The concept that cardiac rupture can be diagnosed only in the moribund patient or at autopsy probably is not true today. Van Tassel's<sup>1</sup> data suggest that rupture of the heart may be clinically evident for a sufficient period of time prior to death to permit the diagnosis to be made. Biorck et al<sup>5</sup> made the clinical diagnosis in eight



**Figure 1.** Note atrial premature beats (9:05) sinus tachycardia (9:15), A-V. dissociation (9:45), Mobitz type IA-V block (9:45).

A-V = atrio-ventricular

patients on the basis of a sudden circulatory arrest in association with sustained QRS configuration for some minutes. Meurs<sup>3</sup> and Mogen-sen<sup>2</sup> suggest that bradycardia would be present in all such patients. The number of patients reported is rather small, however, and at this time it cannot be said with certainty that bradycardia is a *sine qua non* for the clinical diagnosis of myocardial rupture. It was not present in our patient.

It might be argued that rupture did not occur on 9/13 but rather just prior to death on 9/19. This is unlikely for several reasons. In patients dying from myocardial infarction, sinus rhythm is not often found at the time of circulatory arrest. In Biorck's series of 529 patients with acute myocardial infarction there was one false positive diagnosis. In our patient the presence of markedly adherent clots to the walls of the pathway formed by the tear and the appearance of semi-clotted blood also suggest that the clinical findings on 9/13 were related to the rupture. It

certainly is possible that clots may seal the perforation after only a small amount of blood has leaked into the pericardial sac, as is the case in false aneurysm of the left ventricle.

What practical conclusions can be derived from this report? Since rupture of the myocardium will certainly lead to death, prompt surgical intervention is mandatory when the condition is diagnosed, despite the dismal results obtained thus far in four cases<sup>6,7</sup> reported in the literature. On the other hand, if persistent sinus mechanism with circulatory arrest is found in a significant number of other conditions complicating myocardial infarction, such as sudden pump failure, surgical intervention with the purpose of relieving hemopericardium could have disastrous consequences.

It is hoped that the report of this case will stimulate study and report of other conditions which might give a false positive diagnosis of myocardial rupture.

### Summary

A case of myocardial rupture secondary to acute myocardial infarction is reported. The patient survived for about six days following presumed rupture. The electrocardiographic findings are discussed.

Recognition of such complication might lead to prompt surgical intervention:

- Electrocardiogram in myocardial rupture
- Myocardial infarction, complications
- Myocardial rupture
- Heart rupture



**Figure 2.** Idio-ventricular rhythm.

# *Categorization Of Hospital Emergency Medical Capabilities in Illinois: A Statewide Experience*

BY DAVID R. BOYD, M.D.C.M., WINIFRED ANN PIZZANO, B.A., PATRICIA A. SILVERSTONE,  
B.A.Ed. AND TERESA L. ROMANO, B.S.N.

The categorization of hospital capabilities to render effective emergency medical treatment has been a subject of increasing interest to the entire health community. It is anticipated that the concept of categorization of hospital emergency capabilities will be an essential and effective step in the process of improving emergency medical care across the nation. Of national scope, this concept involves the effectiveness of utilization of emergency personnel and facilities, with appropriate attention to such elements as quality of care, cost, community acceptance, and the applicability of categorization to urban and rural areas.<sup>1</sup>

The categorization process has taken different forms in several areas across the nation. This variance may be an effective way to respond to the charge of the American Medical Association (AMA) Conference recommendations and guidelines for "The Categorization of Hospital Emergency Capabilities."<sup>2</sup> The AMA guidelines, established in 1971, concluded with a strong recommendation for field testing with secondary modified guidelines to be developed later, based on the wisdom of experience.

The State of Illinois has, over the past three years, gained considerable experience and achieved apparent success in the implementation of a hospital categorization program. The de-

DAVID R. BOYD, M.D.C.M., is Chief of the Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health, and Assistant Professor of Surgery, The Abraham Lincoln School of Medicine at the University of Illinois College of Medicine. WINIFRED ANN PIZZANO, B.A., is the Assistant of the Division Chief, Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health. PATRICIA A. SILVERSTONE, B.A. Ed., is a former Special Assistant for Health Planning and Public Education, Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health. TERESA L. ROMANO, B.S.N., is Operations Director for the Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health.

velopment of a trauma care system in 1971,<sup>3,4</sup> and the initiation of an effort to further expand this program into a Total Emergency Medical Services System,<sup>5,6</sup> involved initially a functional categorization of selected "Trauma Center Hospitals" for a specific patient group—the critically injured—and has been extended to include 261 acute care hospitals for all aspects of emergency medical care. The first Areawide EMS Plan with categorization of hospital emergency capability in Illinois was reported in this *Journal* by Forkosh.<sup>7</sup> The general approach reported in this article was further refined and amplified to become a teaching model for the entire state.

At the time of this writing, the Trauma Program and hospital net are essentially complete and the first years' experience with planning, coordinating, and implementing of all Illinois general hospitals into some 40 areawide EMS plans in compliance with the Illinois Categorization Law (PA 76-1858) has been accomplished. Further areawide planning and implementation of a wide spectrum of EMS activities is now in progress throughout the state, utilizing and further supporting this categorized and planned areawide approach to the delivery of emergency medical services.

A chronological and programmatic narrative of the Illinois experience is the subject of this report.

## **General Principles**

Categorization of hospital emergency capability to comply with bureaucratic regulations or restrictive legislative mandates will not, of itself, improve the quality of emergency medical care. Categorization of hospital emergency medical care must be done in relationship to patient needs, community capability, and improved resources utilization. These efforts must be stylized to meet the needs of specific emergency patients

which will significantly effect improvement in overall medical care. In Illinois, the planning process emphasized this important issue and required an assessment of the primary care capabilities and available transfer mechanisms of the following six clinical patient groups in each areawide plan: trauma, cardiac (acute coronary), high-risk infant, poison control, drug overdose and alcohol detoxification, and psychiatric emergencies.

The statewide categorization program in Illinois was based on the premise of presenting the potential benefits to emergency medical patients, physicians, nurses, allied health workers, and hospitals. Initial awareness of the issues and problems of categorization had previously been encountered with the functional categorization of some 45 Trauma Centers across the state during the preceding year. The Trauma Program was a successful learning model and was effective in emphasizing the beneficial aspects of hospital categorization and areawide planning to an entire statewide health community.

Categorization in Illinois has allowed for hospitals to self-categorize their capability, provided that this self-categorization was consistent with effective areawide EMS planning. Hospitals then had to plan with contiguous hospitals in a geographic area, with no deletion of less favored hospitals being allowed. To perform this, each hospital in an areawide plan had to designate one administrator, one physician, and one nurse for membership on the Categorization Committee to develop the areawide plan (Figure 1). An "area" for EMS planning was geographically described to meet functional needs of emergency medical patients. These coincided fairly well with existing and developing Comprehensive Health Planning "B" planning regions and subregions; in fact, they are a leading geographic determinant in this and future planning efforts.

To facilitate planning for the development of a "systems approach" to emergency medical care, the Illinois Department of Public Health, Division of Emergency Medical Services and Highway Safety was identified as the governmental lead agency with overall initiating responsibility.

Illinois has utilized non-ranking terminology for its hospital categorization program. By Illinois law, hospitals are now classified for the provision of Comprehensive, Basic or Standby emergency medical care.<sup>8</sup> Trauma Center hospitals have been designated as Regional, Areawide, Local, and "Special" Regional. A func-

tional comparison of these titles and the AMA categorization is shown in Table I. As future experience and the real potential of these efforts is gained, a closer approximation to the AMA (or as modified) categorization is anticipated.

**TABLE I**  
**HOSPITAL CATEGORIZATION SCHEME**

| Illinois Law<br>PA 76-1858                      | Illinois Trauma<br>Program | AMA Guideline<br>Recommendations |
|---|----------------------------|----------------------------------|
|   | Regional                   | I                                |
| Comprehensive<br>24 Hour M.D.<br>Subspecialties | Areawide                   | II                               |
| Basic<br>24 Hour M.D.                           | Local                      | III                              |
| Standby<br>24 Hour R.N.                         |                            | IV                               |

In order to be acceptable, every emergency medical plan must have and now has the following: a strict geographic definition of the area of responsibility, working relationships between the area hospitals, and a systems description of the six clinical patient groups as listed above.

In a similar fashion, each plan includes the other essential EMS subsystems of communications, transportation, professional training and education, public education, program monitoring, and evaluation. These activities are now being instituted, and area plans are being integrated into one of nine regional EMS service systems. The Illinois concept and definition of a medical "region" involves total medical competence for all routine as well as the most special emergency medical problems. Only very special or unique emergency medical problems (spinal cord, extensive burn, hyperbaric treatment, etc.) need to be removed from a medical "region."

### The Illinois Experience

In 1969, the Illinois legislature passed enabling legislation which allowed hospitals to self-categorize and to participate in an areawide plan for the delivery of emergency medical services. This permissive law was implemented in only one area of Illinois (St. Francis Hospital, Peoria, and Eureka Hospital, Eureka). In July of 1971, the Illinois Trauma Program became operational. This program was not based upon a specific law; however, it resulted in the initial development of a system for the delivery of

emergency medical services based on areawide and regional medical planning. This program aimed at the identification and functional categorization of 50 hospital Trauma Centers dedicated to the care of the critically injured patient. The functional hospital categories of trauma care (Regional, Areawide, and Local) were necessarily selective to provide well-identified access points to the emergency care essential to the life-threatened accident victim.

The success of the Illinois Trauma Program has been due, in part, to the classification of treatment centers based on a hospital's care capability and the distribution of selected trauma patients by the seriousness of their injuries. In this system, patients are sequentially transported to more advanced centers for specialized intensive trauma care as the patients' clinical needs are identified. This basic areawide triage of trauma patients has been shown to result in better care for the critically injured.<sup>9</sup> It is the general impression that trauma patient care is now improving in all Trauma Centers and that prehospital (primary) transportation and inter-hospital (secondary) transportation also are improving statewide. In fact, prehospital mobile intensive care is now being considered by most of the larger communities in Illinois.

Based on the apparent success of the initial Trauma Program in effecting inter-hospital cooperation and areawide planning, the Illinois Hospital Licensing Board subsequently ruled that the permissive categorization law passed in 1969 be made mandatory as of July 1, 1973. This law provides that all hospitals with emergency rooms must participate cooperatively in an areawide plan to provide medical emergency services on a community and areawide basis.

### **Areawide Hospital**

### **Emergency Service Plan Development**

The Division of Emergency Medical Services and Highway Safety assumed the responsibility of initiating the planning process at the local level, and served as a resource (professional, technical, staffing and consultation) to the local EMS planning committees. In addition, the Division continues to serve as a liaison between the local planning committees/councils, the Illinois Division of Health Facilities (Hospital Licensing), and Comprehensive Health Planning Agencies.

Distributed in December, 1972, were guidelines, *Areawide Emergency Services: A Manual for the Illinois Plan for a Comprehensive Emer-*

*gency Care System.* This manual includes the Emergency Planning Law (PA 76-1858), a description of a systems approach to the delivery of emergency services, discussions of the EMS subsystems, and an identification of the planning steps required to comply with PA 76-1858. The manual was developed in "loose leaf" form and modeled after the AMA guidelines to allow for midcourse corrections based on experiences gained in field operation.

Although the Illinois law requires a comprehensive plan for "emergency medical services" including all EMS subsystems, emphasis was placed on hospital categorization and the development of a basic regionalized medical emergency system utilizing current resources and building on the existing Trauma Program's initial structure and functional components further systems designs were planned for acute coronary, high-risk infant, poisoning drug overdose and alcohol detoxification, and psychiatric problems.

### **The Planning Process**

To initiate this planning process, the Division of Emergency Medical Services and Highway Safety held a series of 14 regional workshops across the state to provide technical and professional assistance to local planning groups. All appropriate health providers in each geographic service area were invited to attend and participate. At the workshops, representatives from the Illinois Hospital Association, local ("B") and state ("A") Comprehensive Health Planning Agencies, Illinois Nurses Association, and Illinois State Medical Society participated with local area physicians, nurses, hospital administrators, ambulance operators, etc., to initiate and develop their areawide EMS plans.

### **Defined Geographic Area**

All area acute care general hospitals with emergency rooms or departments met to become part of an Areawide Hospital Emergency Service Plan. Each plan required a specifically defined geographic service area. Participation by professional representatives from contiguous and interdependent areas were along the lines of established state, regional, and subregional designs.

The Illinois Department of Public Health and the Hospital Licensing Board interpreted the regulations (PA 76-1858) so that in the rural Illinois each geographic area would be approximately 25 miles in radius around a "comprehensive" or "basic" emergency room. This approach

has been effective in downstate Illinois, and follows closely the previous Trauma Center area planning and hospital designations.

Within the Chicago metropolitan area, the Illinois Department of Public Health recognized the 12 functioning Comprehensive Health Planning "B" suborganizations established on previous service areas and planning agency relationships. These 12 planning agencies all related to the Chicago area Emergency Service Commission for overall planning, inter-area considerations, and primary plan review. This EMS Commission was recognized by the Comprehensive Health Planning "A" Agency as the responsible plan review group for emergency services in the Chicago metropolitan area.

There are, at the present time, some 40 areawide hospital emergency service plans functioning with continuous EMS planning. All of these plans essentially include at least one designated Trauma Center as the basic or comprehensive emergency hospital providing 24-hour physician coverage. This hospital Trauma Center is, in many areas, the focal point for ongoing EMS activities.

### **Illinois Hospital Emergency Facility Categorization Guidelines**

Categories of emergency services have been established which allow hospitals to identify and declare the level of emergency services appropriate to their resources. In Illinois, every hospital with an emergency room must provide emergency services in one of the three classifications: Comprehensive, Basic, or Standby. The essential elements of these emergency service classifications are capsulized in Table 2.

The American Medical Association presently endorses four emergency department/room categories.<sup>2</sup> The Illinois experience over the past year has shown that the identification of at least three levels of hospital emergency categorization allows for the successful initial development of comprehensive areawide emergency medical planning. Within the three categories listed above, many hospitals will vary in their present overall capability. It is anticipated that more uniformity among categorized hospitals using existing or modified categorization standards will occur with time.

In Illinois, all hospitals, irrespective of their category of emergency services, must have adequate provision for rendering immediate first aid, emergency care, and life support to persons requiring such treatment on arrival at the hospital. In each areawide plan there must be,

**TABLE II**  
**OUTLINE OF EMERGENCY SERVICE CLASSIFICATIONS**

#### **Comprehensive Emergency Treatment Services**

1. Illinois licensed physician in the emergency room 24 hours a day.
2. Specialties of medicine, surgery, obstetrics, and pediatrics on call, and available within minutes, 24 hours a day.
3. Additional subspecialties on call and available within minutes, 24 hours a day.
4. Laboratory and X-ray departments staffed 24 hours a day.
5. Pharmacy on call within minutes, 24 hours a day.

#### **Basic Emergency Treatment Services**

1. Illinois licensed physician in the emergency room 24 hours a day.
2. Specialties of medicine, surgery, obstetrics, and pediatrics on call, and available within minutes, 24 hours a day.
3. Laboratory, X-ray, and pharmacy departments on call within minutes.

#### **Standby Emergency Treatment Services**

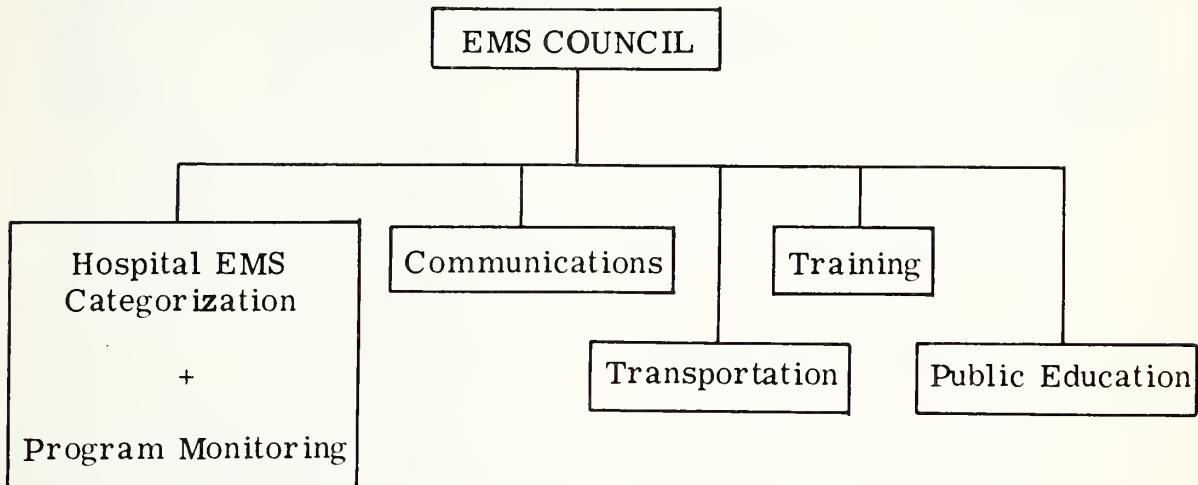
1. Registered nurse available at all times.
2. Illinois licensed physician on call at all times.

by law, at least one "comprehensive" or "basic" designated emergency room. Once a defined geographic area is determined, the self-categorizations of each of the participating facilities may be readjusted as necessary to meet areawide needs. With the development of EMS planning and categorization, there has been an increase in 24 hour physician coverage in downstate Illinois.<sup>6</sup> Hospital physician coverage in the Chicago area has remained relatively constant and area plans are now being further supported by a citywide ambulance ordinance that directs ambulances with critical patients to comprehensive emergency hospitals.

### **Review and Approval of Areawide Emergency Service Plans**

The 40 areawide hospital emergency service plans were developed after the regional workshops were held across the state, and staff personnel and trauma coordinators served as consultants to local planning groups, clarifying what was required and how to further identify available resources. All plans were submitted to appropriate local Comprehensive Health Planning agencies for review and comment. They were then passed to the Illinois Department of Public Health and further reviewed by the Division of Emergency Medical Services and Highway

## EMS PLANNING ORGANIZATION



**Figure 1. The Emergency Medical Services Council and Emergency Medical Services Committee and Subcommittee structure adapted to local EMS areawide planning. Program initiation and legal authority are imparted through the Hospital Categorization Subcommittee.**

Safety for professional and technical adequacy. The Emergency Service Advisory Committee of the Hospital Licensing Board made final review before the plans were submitted to the Director of the Illinois Department of Public Health for approval. During the first year (1973) all plans received "conditional approval," and after some 90 days, finalizing progress reports were resubmitted to the Illinois Department of Public Health.

The local Emergency Medical Service Committee is responsible for the development, implementation, and ongoing evaluation of each areawide emergency service plan. The required minimum membership of this committee is a physician, a nurse, and an administration representative from each participating hospital. In addition to the EMS committees, active subcommittees have since been formed for communications, transportation, professional training and education, public education, and program evaluation (see Figure 1).

### Future Expectations of Areawide Planning Process

The progress made over the past year in areawide emergency service planning in Illinois

has surpassed expectations. The task of developing coordinated and upgraded emergency services on a community and areawide basis has been initiated. The local planning authority for the medical plan has been identified as the Emergency Service Council, usually under the Comprehensive Health Planning "B" Agency.

As each EMS planning council/committee further develops its plan, more ancillary emergency service personnel are becoming involved. EMS Councils are being integrated into the local Comprehensive Health Planning "B" Agency activities. The Council itself is made up of health providers and consumers and is functioning as the overall advisory body to the specific area subcommittees on categorization, communications, transportation, professional training and education, and public education.

### Public Awareness

All public education subcommittees are now working on programs to inform their respective communities of the necessity for hospital categorization and areawide EMS planning. This public education effort will soon be expanded to inform the public and to gain support for improvements in communications ("911"), am-

bulance services, and a wide variety of other essential emergency medical services. The Illinois Division of the American Trauma Society is assisting in these public education efforts, and state medical, nursing, and hospital associations are being asked to lend support. State and local health departments will be utilized to provide professional and material support to local emergency medical services efforts now gaining considerable momentum across Illinois.

### Summary

Categorization is only the first, and most important, of the necessary steps to a true regional EMS systems implementation. The goal of this approach must be the continual upgrading of trauma and emergency medical capability across the community. This approach can produce other benefits including better cost effectiveness and improved resource utilization in those communities which are unnecessarily duplicating their efforts, monies, and medical manpower.

By defining the problem for critically injured patients, and by categorizing hospital emergency capabilities for this group, significant progress has been realized in Illinois, where a total hospital emergency categorization effort has been accomplished. This program was facilitated by the statewide experience gained in the trauma categorization model. All areawide plans were based on self-categorization of each participating hospital and consistent with area EMS deficiencies and strengths. Each area plan has attempted to initiate a "systems approach" to the six identified major clinical patient groups. Equipment

purchases and other financial allocations were then made to support these local EMS plans.

A major task of public education lies ahead for Illinois. One enthusiastic individual, agency, or association will not solve this massive health problem. It will require a consortium of all interested health professionals and agencies working together rather than in competition. These participants will need to realize that individual efforts must be consistent with an overall program of improving areawide and regional emergency medical services. ▶

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## Clinics for Crippled Children Listed for August

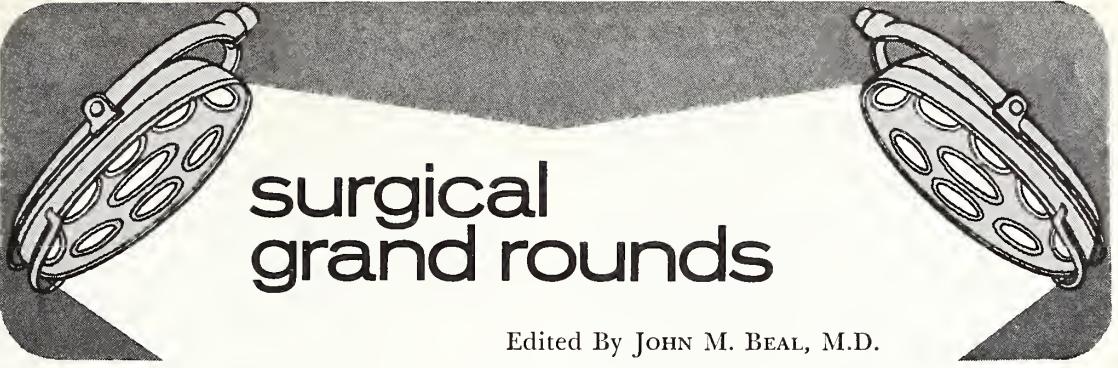
Twenty-five clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 17 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

|        |    |   |
|--------|----|---|
| August | 1  | Rockford—Rockford Memorial Hospital             |
| August | 1  | Lake County Cardiac—Victory Memorial Hospital   |
| August | 6  | Belleville—St. Elizabeth's Hospital             |
| August | 7  | Carlinville—Carlinville Area Hospital           |
| August | 7  | Springfield Pediatric-Neurology-Diocesan Center |
| August | 7  | Hinsdale—Hinsdale Sanitarium                    |
| August | 8  | Sterling—Sterling Community Hospital            |
| August | 8  | Springfield—St. John's Hospital                 |
| August | 8  | Kankakee—St. Mary's Hospital                    |
| August | 9  | Chicago Heights Cardiac—St. James Hospital      |
| August | 12 | Peoria Cardiac—St. Francis Children's Hospital  |
| August | 13 | Peoria—St. Francis Children's Hospital          |
| August | 13 | East St. Louis—Christian Welfare Hospital       |
| August | 14 | Champaign-Urbana—McKinley Hospital              |
| August | 15 | Bloomington—Mennonite Hospital                  |

|           |   |
|-----------|---|
| August 15 | Elmhurst Cardiac—Memorial Hospital of DuPage County |
| August 20 | East St. Louis—Christian Welfare Hospital           |
| August 20 | Rock Island—Moline Public Hospital                  |
| August 21 | Chicago Heights—St. James Hospital                  |
| August 23 | Evanston—St. Francis Hospital                       |
| August 23 | Chicago Heights Cardiac—St. James Hospital          |
| August 26 | Peoria Cardiac—St. Francis Children's Hospital      |
| August 27 | Peoria—St. Francis Children's Hospital              |
| August 28 | Springfield Pediatric-Neurology—Diocesan Center     |
| August 28 | Aurora—St. Joseph Mercy Hospital                    |

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children. ▶



# surgical grand rounds

Edited By JOHN M. BEAL, M.D.

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion. Patient presentations from Northwestern Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of December 4, 1973.*

## Hemangiosarcoma of Breast

**Dr. Mitchell Grasseschi:** Two cases will be presented briefly. First, a 59-year-old Black woman was admitted to Wesley Pavilion November, 1973, with a mass in her left breast. In December 1972, she had a mass removed from the left breast at another hospital. She was told that this was a benign tumor. Two months later, she noticed tenderness in the same breast and a recurrence of a firm mass. There was no change observed until four weeks prior to admission when she noticed marked increase in the size of the mass associated with warmth and discoloration of the skin of the breast. Past history is significant only in that she breast fed her child and noted that the left breast was deficient in milk compared to the right.

Physical examination at the time of admission was unremarkable except for a large mass in the inferior lateral portion of the left breast, described by the initial examiners to be approximately the size of a grapefruit. Blueish discoloration of the skin over the mass was noted associated with increased warmth. Admission blood count, urinalysis and chest X-ray were negative.

A needle biopsy was performed the day after admission and reported as hemangiosarcoma. A liver scan showed a suspicious defect in the left lobe of the liver. An X-ray skeletal survey was negative. Mammograms were obtained. A simple mastectomy was performed November 9, 1973. Her post operative course was uncomplicated.

The second case: A 22-year-old white woman was admitted December, 1967, with a small, fairly movable non-tender nodule in the left breast, and a larger tender mass in the right

breast. Biopsy of both masses was performed. The lesion in the left breast mass was reported to be fibroadenoma. The right breast mass was found to be a hemangiosarcoma. In January, 1968, a right simple mastectomy was performed. She was well until July, 1969, when she noted a nodule in her scalp in the occipital region. This was excised and microscopic examination revealed metastatic hemangiosarcoma. She developed numerous subcutaneous recurrences and she was admitted for radiation therapy in January, 1970. At that time she had subcutaneous metastasis in the scalp, neck, left axilla and recurrence in the mastectomy scar. After cobalt therapy, she was well until April, 1970, where more subcutaneous metastases appeared. Chemotherapy was started with cytoxan and Methotrexate. A variety of chemotherapeutic agents were used without demonstrable benefit.

In October, 1970, she was found to have a pelvic mass. She was admitted a month later with severe abdominal pain. She was taken to the operating room and was found to have hemangiosarcoma metastatic to both ovaries, with hemorrhage and necrosis of the ovaries and 700 cc. of blood in the peritoneal cavity. A bilateral oophorectomy was performed. The liver was reported to be normal at laparotomy, but the spleen was thought to be enlarged. She recovered from this procedure but developed some weakness in her legs. She subsequently became paraplegic and died.

**Dr. Hector Battifora:** The excised breast from the first patient, the 59-year-old woman, consisted of several confluent masses of hemorrhagic, somewhat necrotic tumor with very poorly circumscribed margins. The tumor contained large

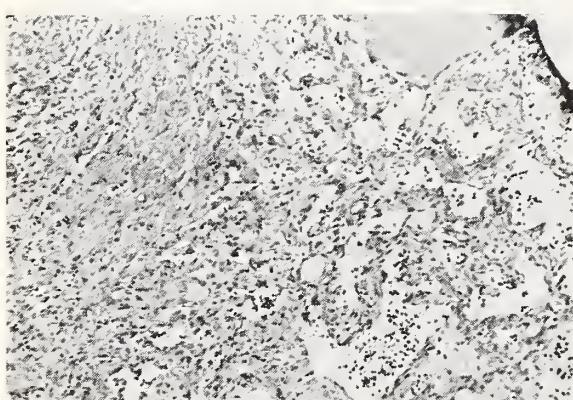


Figure 1. H & E stained section from tumor #1. Cavernous vascular spaces as well as more solid areas are shown.

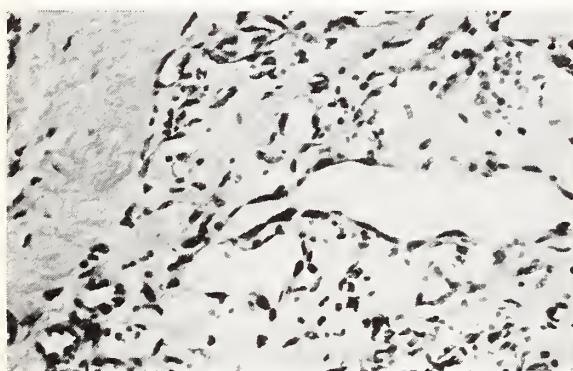


Figure 2. H & E stained section from tumor #2. Hyperchromatic endothelial cells line irregular vascular spaces. Innocent appearance of tumor is betrayed by its true malignant potential as evidenced by later development of disseminated metastases.

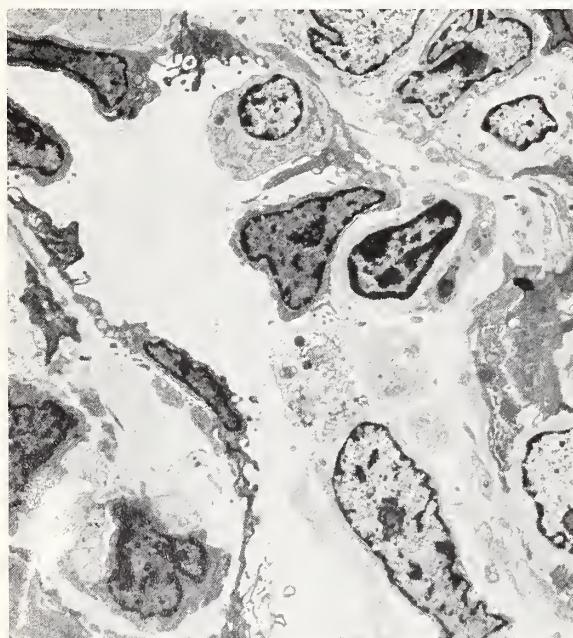


Figure 3. Electron micrograph from Case 1. Pleomorphic endothelial cells are shown lining a capillary.

blood filled lakes. A superficial examination with the microscope might lead us to believe that we are dealing with a cavernous hemangioma which is a mistake not infrequently made by the inexperienced. However, I think that even at low power, one can notice that there are grapelike clusters of cells hanging from the endothelial surface seemingly due to a local excess of cells. This strongly militates against a diagnosis of simple hemangioma. On higher magnification, one can see that the endothelial cells pile up on each other. In addition, there are pleomorphic, occasionally bizarre endothelial cells. There were also solid areas of growth in which the capillaries were very inconspicuous. (Figure 1) Changes of this type are enough to warrant a diagnosis of hemangiosarcoma regardless of the tissue source. This is particularly true of breast lesions since hemangioma is a distinct rarity in the breast. One should be very cautious about accepting, *prima facie*, a diagnosis of hemangioma of the breast. In our experience, angiosarcoma is a more common tumor than hemangioma of the breast.

The second case, the younger patient, had a diffuse enlargement of the breast, a biopsy revealed a similar appearance to the previous case. (Figure 2)

Electron microscopy was done in both cases revealing that the tumor cells maintained features typical of endothelial cells. (Figure 3).

**Dr. Mitchell Grasseschi:** A review of the literature reveals how rare this tumor is. There have been only 43 cases reported from 1907 to the present. The terms hemangiosarcoma, hemangioblastoma, metastasizing hemangioma and angiosarcoma are synonymous terms. Schmidt (1887) is credited with the earliest reported hemangiosarcomas of the breast and described tumors of the breast which metastasized without involving the lymph nodes. In 1907, Borman reported a case of metastasizing hemangioma which was histologically benign; however, the patient died 2½ years later from multiple metastases.

From the clinical standpoint, this tumor is very rare. It is most frequent among young women in the second to third decade of life. The age range of the 43 reported patients was from 15-82 years with half being 26 years or younger. Some have suggested that these tumors may be hormone related. Five of the reported cases were pregnant at the time of discovery of the tumor. The tumor is usually painless, rapidly growing and of short duration. The average sur-

vival after diagnosis is approximately 2½ years. Among the reported cases, only two patients survived more than five years, one for seven years and one for fourteen years. Hemangiosarcoma has been said to have the worst prognosis of all breast tumors. The tumor usually presents as a deep mass. Occasionally when it is superficial, there is bluish discoloration of breast. Often there is a reported history of trauma. Seven cases were thought initially to be a hematoma and were treated expectantly. Hemangiosarcoma tends to occur slightly more often in the right breast than in the left, although carcinoma is found slightly more in the left breast. They metastasize primarily to the lungs, skin, the subcutaneous tissue and the bones and rarely to the lymph nodes. Histologically, these tumors are deceptively benign in appearance. Fourteen of the reported cases initially had a diagnosis of benign hemangioma. As Dr. Battifora mentioned, benign hemangiomas are even more rare than are hemangiosarcomas.

There does not seem to be any effective treatment for this problem. Simple mastectomy seems to be adequate when the disease is advanced. It is interesting to note that of the two patients that did survive five years, both had the initial diagnosis of malignant hemangiosarcoma and both had radical mastectomy.

**Dr. Peter Rosi:** There is little to be added to

the discussion by Dr. Grasseschi. From a review of the literature, the most frequently performed operation was either a radical or a simple mastectomy, although wide segmental resections of small tumors and subcutaneous mastectomies have been reported. The value of post operative irradiation has not been established; however, Ackerman reported one patient in whom the breast angiosarcoma was completely destroyed by X-ray irradiation.

The course of the disease is probably not influenced by the surgical procedure, but most likely by the biological behavior of the tumor. Histologic studies have shown that the greater the number of dividing cells per high power field, the poorer the prognosis.

The present prevailing management of angiosarcoma of the breast is a simple mastectomy with microscopic examination of the edges of the resected specimen for residual malignancy. Although the value of post operative irradiation and chemotherapy has not been determined, they may be, nevertheless, advisable. One of the characteristics of hemangiosarcoma of the breast has been a high rate of recurrence at the operative site. ▶

#### Reference

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75  
YEARS

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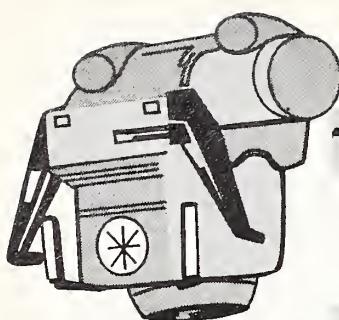
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## the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

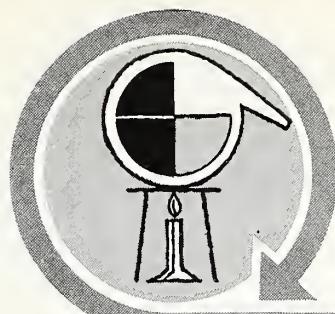


The patient is a 42-year-old white female with the chief complaint of recurring attacks and of right upper quadrant pain. Physical examination revealed tenderness in the right upper quadrant, pallor and a prominent spleen. Laboratory work revealed a congenital hemolytic anemia.

What's your diagnosis?

1. Carcinoma of the lung
2. Extramedullary Hematopoiesis
3. Neurofibroma
4. Duplication of the Esophagus

(Answer on page 44)



# new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

**Single Chemicals**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

## The following new drugs have been marketed:

### SINGLE CHEMICALS

**INTROPIN** Adrenergic Rx  
Manufacturer: Arnar-Stone Laboratories  
Nonproprietary Name: Dopamine HCl  
Indications: Hemodynamic imbalances present in shock produced by a variety of causes.

Contraindications: Pheochromocytoma  
Dosage: Follow instructions in package insert  
Supplied: Ampules, 5cc. cc/40 mg.

**NICOLAR** Cholesterol Reducing Agent Rx  
Manufacturer: Armour Pharmaceutical Comp.  
Nonproprietary Name: Niacin  
Indications: Hypercholesterolemia and hyperbeta lipoproteinemia

Contraindications: Hepatic dysfunction or acute peptic ulcer.  
Precautions: See package insert  
Dosage: Two to 4 tablets daily  
Supplied: Tablets, 500 mg.

**QIDAMP** Semisynthetic Penicillin Rx  
Manufacturer: Mallinckrodt Pharmaceutical Prod. Div.  
Nonproprietary Name: Ampicillin trihydrate  
Indications: Susceptible infections caused by Gram-negative and Gram-positive organisms.

Contraindications: Hypersensitivity to penicillin  
Dosage: See package insert  
Supplied: Capsules, 250 and 500 mg. ampicillin eq. Powder f. oral suspension—125 and 250 mg/5cc reconstituted

**ULCOLAX** Laxative o.t.c.  
Manufacturer: Ulmer Pharmacal  
Nonproprietary Name: Bisacodyl  
Indications: Constipation  
Dosage: Two to three tablets, taken at bedtime or before breakfast, children over 6 one tablet.  
Supplied: Tablets, 5 mg.

**DOWPEN VK** Penicillin Deriv. Rx  
Manufacturer: Dow Pharmaceutical  
Nonproprietary Name: Phenoxymethyl Penicillin Potassium  
Indications: Infections due to penicillin G sensitive organisms  
Contraindications: Hypersensitivity to penicillin  
Dosage: See package insert  
Supplied: Tablets, 250 and 500 mg.

**HYTINIC** Hematinic o.t.c.  
Manufacturer: Hyrex-Key Pharmaceuticals  
Nonproprietary Name: Polysaccharide iron complex  
Indications: Iron deficiency anemia  
Dosage: Capsules—one to two tablets daily  
Supplied: Elixir—Adults, one to two teaspoonsfuls daily  
Children, 6-12 one teaspoonful daily; 2-6 1/2 teaspoonful daily; under 2 1/4 teaspoonsful daily  
Capsules, 150 mg. elemental iron  
Elixir, 5 cc/100 mg. elemental iron, alcohol 10%

**METRETONE OPHTH. SOL** Eye preparation Rx  
Manufacturer: Schering Corporation  
Nonproprietary Name: Prednisolone sod. phosphate  
Indications: Steroid-responsive inflammatory conditions of the eye.

Contraindications: Superficial herpes simplex keratitis, viral infections of the cornea and conjunctiva. Tuberculosis of the eye and fungal diseases of the ocular or auricular structures.  
Dosage: Duration varies with type of lesion. Eye: One to 2 drops every hour during the day and every two hours during the night. Reduce dosage as progress occurs.  
Ear: Initial dose 3 to 4 drops 2 to 3 times daily, reduce gradually.  
Supplied: Dropper bottle, 5cc/0.5%

### COMBINATION PRODUCTS

|                          |   |        |
|--------------------------|---|--------|
| <b>AMCILL-GC</b>         | Penicillin Deriv.   | Rx     |
| Manufacturer:            | Parke-Davis   |        |
| Composition:             | Dry powder for reconstitution   |        |
| Indications:             | Ampicillin trihydrate eq. 3.5 Gm  |        |
| Contraindications:       | Probenecid 1.0 Gm   |        |
| Precautions:             | Uncomplicated gonorrhea   |        |
|                          | Hypersensitivity to penicillin or probenecid  |        |
|                          | Do not use in patients with blood dyscrasias, uric acid kidney stones or during acute attack of gout. |        |
| Dosage:                  | Single dose administration  |        |
| Supplied:                | Bottles containing dry powder mixture.  |        |
| <b>ENEMEEZ</b>           | Enema   | o.t.c. |
| Manufacturer:            | Armour Pharmaceutical Comp.   |        |
| Composition:             | 100 cc. contain   |        |
|                          | Sod. biphosphate  | 16 Gm  |
|                          | Sod. phosphate  | 6 Gm   |
| Indications:             | Cleansing enema   |        |
| Supplied:                | Bottles, 4½ fl. oz.   |        |
| <b>KEY-PLEX Capsules</b> | Vitamins and Minerals   | o.t.c. |
| Manufacturer:            | Hyrex-Key Pharmaceuticals   |        |
| Composition:             | Ascorbic acid   | mg.    |
|                          | Niacinamide   | 300    |
|                          | Thiamine mononitrate  | 50     |
|                          | d-Calcium Pantothenate  | 15     |
|                          | Riboflavin  | 10     |
|                          | Pyridoxine HCl  | 5      |
|                          | Magnesium sulfate   | 70     |
|                          | Zinc sulfate  | 80     |
| Indications:             | Vitamin and mineral deficiencies.   |        |
| Dosage:                  | One capsule daily with meals; in severe deficiencies three capsules.                                  |        |

Supplied: Capsules

|                         |   |         |
|-------------------------|---|---------|
| <b>POXY COMPOUND 65</b> | Analgesic, Non-narcotic   | Rx      |
| Manufacturer:           | Sutcliff & Case   |         |
| Composition:            | Propoxyphene HCl  | mg.     |
|                         | Aspirin   | 65      |
|                         | Phenacetin  | 227     |
|                         | Caffeine  | 162     |
| Indications:            | Relief of mild to moderate pain   |         |
| Contraindications:      | Do not use in children, use with circumspection in pregnancy.                                   |         |
| Precautions:            | Tolerance has been reported in some patients  |         |
| Dosage:                 | One capsule three to four times daily.  |         |
| Supplied:               | Capsules  |         |
| <b>PRETTS</b>           | Antiobesity Preparation   | o.t.c.  |
| Manufacturer:           | Marion Laboratories   |         |
| Composition:            | Alginic acid  | 200 mg. |
|                         | Sod. carboxymethyl-cellulose  | 100 mg. |
|                         | Sod. bicarbonate  | 70 mg.  |
| Indications:            | Adjunct use in diet control   |         |
| Dosage:                 | Chew 2 to 4 tablets, followed by a full glass of water, 30 minutes before meals and at bedtime. |         |
| Supplied:               | Tablets   |         |
| <b>NEW DOSAGE FORMS</b> |   |         |
| <b>ZARONTIN Syrup</b>   | Anticonvulsant  | Rx      |
| Manufacturer:           | Parke-Davis   |         |
| Nonproprietary Name:    | Ethosuximide  |         |
| Indications:            | Petit mal epilepsy  |         |
| Contraindications:      | Hypersensitivity to succinimides  |         |
| Dosage:                 | Children 3 to 6 years—one teaspoonful daily; Over 6 years—two teaspoonfuls daily                |         |
| Supplied:               | Syrup, 5cc/250 mg.  |         |

### View Box

(Continued from page 42)

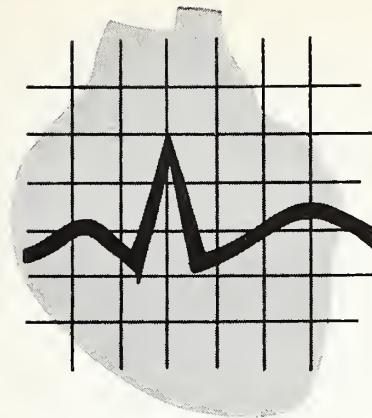
**DIAGNOSIS: Extramedullary Hematopoiesis** — This is a rare condition which should be born in mind in any case of a paravertebral mass in a patient with severe anemia, with or without splenomegaly, hepatomegaly and gall stones from hemolysis (Figure 1). Extramedullary hematopoiesis occurs as a compensatory phenomenon in various diseases in which there is inadequate production or excessive destruction of blood cells; extramedullary sites include the liver, spleen, kidney, hilus, thymus, adrenal, appendix, lymph nodes, dura mater, the broad ligaments, prostate, sciatic nerve, breast, and the paravertebral areas of the thorax.

The majority of cases are associated with

congenital hemolytic anemia. It has also been found in thalassemia and sickle cell anemia.

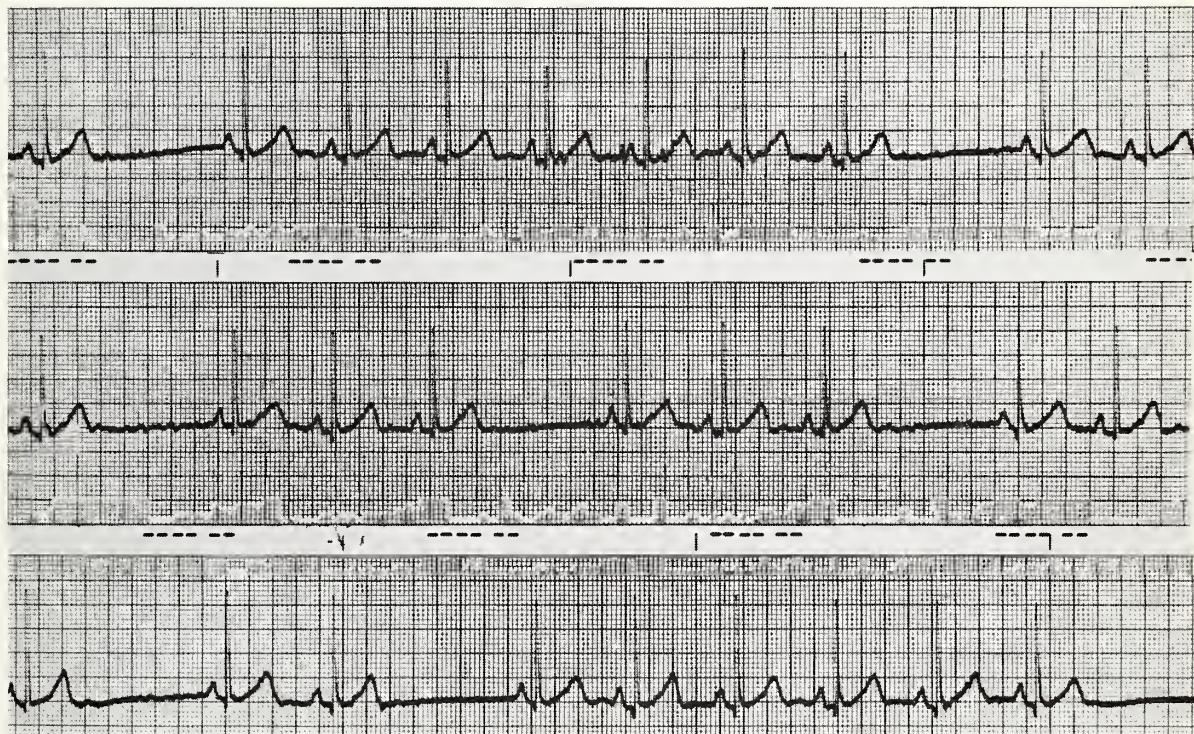
The characteristic roentgenographic finding is of multiple masses, smooth or lobulated in contour and of homogenous density, situated in the paravertebral regions, either unilaterally or bilaterally. A presumptive diagnosis usually can be made when this roentgenographic finding is present in patients with severe anemia and splenomegaly.

The presence of extramedullary hematopoiesis within the thorax usually occasions no symptoms, although paraplegia has been reported in one case.



## ekg of the month

JOHN R. TOBIN, M.D., M.S., RIMGAUDAS, NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
JAMES V. TALANO, M.D., SARAH JOHNSON, M.D. and  
ROLF M. GUNNAR, M.D., M.S./Section of Cardiology,  
Loyola University Stritch School of Medicine



A 49-year-old female was admitted to the psychiatric service with diagnosis of manic-depressive psychosis. She had been on chlorpromazine (Thorazine), thioridazine (Mellaril) and lithium carbonate 300 mg t.i.d. In recreational therapy she fell unconscious and was found to be pulseless. Resuscitative effort was successful. Rhythm strip taken is shown.

### Questions:

**1. The rhythm strip demonstrates:**

- A. Frequent non-conducted premature atrial beats.
- B. Second degree A-V heart block (Mobitz type I).
- C. Severe sinus arrhythmia.
- D. Sinoatrial block.
- E. None of the above.

**2. The treatment of choice is:**

- A. Electrocardiographic monitoring.
- B. Insertion of a temporary transvenous pacemaker.
- C. Determination of blood lithium level.
- D. Stopping all medications possible.
- E. All of the above.

(Answer on page 61)

# The Changing Role of Neonatal Nursing

BY CHARLYN SLADE, R.N., B.S.N./PARK RIDGE

A new nursing role has been created in the area of perinatal medicine, and with it the capacity to save many infants' lives. Specially trained nurses are essential to every neonatal unit. The nursing role in the High-Risk Nursery has changed considerably; the old feelings of doing virtually nothing for premature infants except feeding and changing diapers have changed. The attitude of "don't handle them and the good ones will survive" is certainly outdated; now nursing takes an active part in the care of these critically ill infants. The nurse is no longer the physician's handmaiden; she is a colleague in this setting. In the High-Risk Nursery, assuming proper medical supervision, the difference between success and failure is the difference between excellent and mediocre nursing care.

The high-risk nurse must have certain personal attributes. Very important is her optimism about various therapeutic efforts despite an apparently dismal outlook. The nurse who feels it fruitless to try and save a tiny infant on a respirator does not belong in the unit. Calmness and composure are essential, since emergency situations are frequent and a calm confident atmosphere is most reassuring. The nurse also must know not only what to do, but have the desire to know why it is done. The nurse no longer just follows doctors' orders; she must be able to assess problems and initiate or prepare for the treatment program while awaiting the doctors' instructions and she must anticipate his needs. If she functions in this way, the time saved may mean the life of an infant.

The nurse must develop a special feeling for babies and generate this feeling to others. This feeling consists of an inspiration by, and dedication to, the challenges of the care of newborn infants. Caring for babies is not routine. Babies are fascinating and exciting; they also are involved and complex. They are not good informants so the nurse becomes their interpreter. She senses their needs and relays this information to the physician.

## The Nurse's Role

What exactly is the role of the high-risk nurse? Upon receiving an infant to her unit, the nurse

should scrutinize the maternal record with particular attention to the length of the first and second stages of labor, type of delivery, the analgesia and anesthesia, the time of rupture of membranes and the Apgar scores. She should note whether any special resuscitative measures were needed in the delivery room. All of these things will have some bearing on the infant's adjustment to extrauterine life. The nurse learns to anticipate certain types of behavior from different complications of labor and delivery.

On admission to the nursery the infant is weighed, as all fluids, medications and treatments are based on weight. Providing the infant is breathing and in no immediate danger of a cardio-respiratory arrest, the next priority is regulation of temperature. This is done in several ways. First, the infant is placed on servo control; a probe is placed on the infant's abdomen and the infant then regulates the temperature of the incubator. Second, a heating coil may be placed in the oxygen humidifier. Then, the infant may be placed on a K-pad. Finally, and most important, when working with the infant, always work through the portholes. If the nurse does not set the example of protecting the infant's warmth, it is quite likely that no one else will.

As a member of the team that cares for the infant, the nurse's initial assessment should include evaluation of general appearance, activity and vital signs. Signs of trauma such as cephalhematoma, forcep marks, abrasions or lacerations should be noted. Muscle tone is important. Hypotonia may be a result of drug depression or cerebral asphyxia or peripheral nerve damage.

\*Presented in part at the "Post Graduate Program in Neonatology for Nurses" at Children's Memorial Hospital, November 9, 1972.



CHARLYN SLADE, R.N., B.S.N., is Head Nurse, High Risk Nursery at Lutheran General Hospital, Park Ridge.

Hypertonia may be a result of cerebral anoxia or tetany secondary to hypocalcemia. The nurse must be familiar with the normal to recognize the abnormal. All of these observations are of utmost importance, especially for later comparison.

Since it is the nurse who handles the infant around-the-clock, she is in a position to note subtle changes. A nurse's expertise in the care of newborn patients requires an understanding of the abnormalities of intrauterine growth patterns as they relate to gestational age. An infant's course in the nursery is in large measure determined by these factors; the illnesses that develop postnatally are often peculiar to a particular type of aberrant intrauterine growth pattern. The nurse must be adept at assessing gestational age by using physical and neurological findings. With this skill and a knowledge of maternal factors, the nurse can readily recognize a large number of high-risk infants and plan their management accordingly. For example: infants of diabetic mothers are usually large babies even though they are premature. A 3300-gm infant born after a 34-week gestation may have all the problems of prematurity, such as respiratory distress syndrome. On the other hand a term infant weighing 1500-gm reflects different in utero problems such as placental insufficiency or intrauterine infection; the trained nurse will be on the alert for certain symptoms, such as those of hypoglycemia, which could lead to faster diagnosis and treatment.

The nurse today must be skilled in resuscitative procedures and be able to recognize quickly an infant who is in trouble and respond quickly and efficiently. She should be skilled in use of the ambu bag and mask. Often the nurse makes the first discovery of serious respiratory dysfunction, and she should be able to ascertain that therapy is proceeding effectively and without jeopardy to the infant. The observations of respiratory status made by the nurse are of utmost importance. She should note the infant's color, depth and quality of respirations. Is the infant grunting, flaring, retracting? Is his chest symmetrical? Are good breath sounds heard? The nurse must be familiar with the various respirators used in a neonatal unit. She should know when and why an infant goes on a respirator. Once an infant is on a respirator, the nurse must watch him even more carefully. Frequent suctioning and observation of the infant are essential; the endotracheal tube must be kept patent. The nurses' observations will help the physician

in deciding when to wean the infant off the respirator.

Another indication of respiratory status is acid-base balance. An understanding of acid-base disturbances is essential if the nurse is to correlate laboratory data with the clinical course of her infants and thus assess their progress accurately. This is a part of giving full care contributing to diagnosis. Appreciation of the rationale of appropriate therapy is indispensable if the nurse is to participate intelligently in its administration. Blood gases are routinely done on all infants receiving oxygen therapy. If high concentrations of oxygen over an extended period of time are necessary, the infant will usually have an arterial catheter in place. The ambient oxygen concentration should be monitored continuously with an electronic analyzer. Charting of the infant's appearance and the oxygen concentration are essential.

Electronic monitoring has greatly facilitated the detection of cardiovascular and respiratory difficulties. These instruments are intended for use by skillful personnel; they assist the nurse but are not intended to replace her. Severe difficulty can be detected in the earliest stages by an alert nurse who notes cyanosis even though uninterrupted respirations and heart rate have not yet tripped alarms of monitors. The nurses' observations lead to action, which in turn reflect the quality of care received by the infant.

### **Importance of Feeding**

Nutrition is of utmost importance to the sick infant. Early feeding minimizes the dangers of hypoglycemia, hyperbilirubinemia and excess catabolism. Providing the infant can tolerate it, oral feedings are started as early as 3-6 hours of age. Small quantities of sterile water are offered first. The tiny or feeble premature soon demonstrates whether or not he can take in by his own efforts sufficient food upon which to gain weight. Inability to do so or the appearance of cyanosis during early attempts at feeding calls for institution of gavage feedings. We prefer to use a size 3½ French indwelling catheter because these sick infants often are in such a delicate respiratory balance that the act of passing the gavage tube may induce apnea, cyanosis or bradycardia.

The observations made by the nurse at feeding time are of utmost importance. She needs to recognize how the infant acts before the feeding—is he awake, active and making sucking motions? Does he eat eagerly or does he seem fatigued? The first signs of illness can often be detected

*(Continued on page 50)*

# Opinion & Dialogue

## Is there a need for a drug compendium?

A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for us

a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

### What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it for what type of patient, for how long, in what dose, what benefit his patient is likely to obtain, the risks involved, and cross-reactivity with other drugs.

The information would be based on the package insert and have the same legal status. In fact, a complete compendium with complete and current information might even eliminate the neces-

### Government Health Official

**Henry E. Simmons, M.D.**  
Deputy Assistant  
Secretary for Health  
Department of Health,  
Education and Welfare



### Maker of Medicine

**Joseph F. Sadusk, Jr., M.D.**  
Warner-Lambert Company



A drug compendium, or preferably compendia, should, I believe, be private, not federal, sponsored. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually, and completely revised every year.

### Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed mainly to refresh his memory about drugs he may not use regularly.

package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, not mean a volume of prohibitive size. You don't need a book listing 25,000 products with enormous amount of repetition. Rather, drugs should be arranged class. Mutually applicable information would be provided, along brief discussions pinpointing differences in specific drugs of a class. Listings would be cross-referenced in a useful way.

#### Other Available Documents as Sources of Information

Existing references such as and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not well-referenced by generic name or do not group drugs with similar characteristics, or they do not include the available and legally marketed drugs. And some of those omitted may be very useful.

On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

#### Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess

and indicate instances where a meaningful difference between drugs is pertinent.

#### Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

Id in no way imply control over practitioner's prerogatives.

#### Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some years, my experience as a consultant, and as a faculty member in four or five medical schools, I'd estimate that a doctor uses 30 to 35 drugs regularly. The Physicians' Desk Reference, incidentally, contained about 10,000 entries.

As to whether there should be a federal compendium, in my opinion as stated earlier, the answer is —there should not be one. The usual assumes that existing compendia are inadequate. We're sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is a multifaceted, pluralistic and responsive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluations to company materials. Not all physicians may use such sources as often or as well as they could, but that is the fault of the physician, not of the sources.

In any event, rather than pro-

duce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

#### Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

#### New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per

cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, not the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

#### Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

The Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W.  
Washington, D.C. 20005



# The Changing Role of Neonatal Nursing

(Continued from page 47)

by the nurse at feeding: they include gastric residual from previous feed, abdominal distention, vomiting, refusing to feed, lethargy or cyanosis with feedings. Since the nurse is with the infant around-the-clock, she can make these observations more readily than anyone else.

In the very small or ill infant, early feeding is best accomplished by the intravenous route. Fluid and electrolyte balance are very important to the neonate. Usually no parenteral electrolytes are necessary for the first 24-48 hours. The nurse should know the fluid requirements of infants. Regulation of IV's is done with an infusion pump. We use both the Holter and Ivac. The pump insures a constant flow and prevents over-hydration of the infant, providing a trained nurse is regulating it. The nurse has a large responsibility to making sure that the IV—whether in an umbilical vessel or peripheral one—remains patent and functional. This may be the infant's life-line. In the very small babies even a small infiltrate of IV fluid into subcutaneous tissue may cause sloughing which could lead to infection. The nurse must, therefore, check the site of infusion frequently.

The nurse is also involved in the transport of infants to her center. Responsibility for that infant begins when the infant is accepted. The nurse needs to get a full report from the referring hospital and also inform them what to send with the infant. Some hospitals send trained nurses out to pick up the infant. Everything should be set up so that once the infant arrives treatment can begin immediately.

Another major role of the nurse is working with parents. The old concept of not letting parents in the nursery and just allowing them to look through glass windows is obsolete. Parents should be encouraged to come into the nursery and to do as much for their infant as possible,

even if this means just touching the infant through the portholes of the isolette. The nurse must realize that this is somewhat of a shock to parents; their baby is not the normal one they expected. The many wires attached to the infant, and equipment surrounding the infant may frighten the mother, and she may be understandably unable to focus on her infant. An honest simple explanation of what is going on with her infant is often reassuring to the mother. As the infant progresses, it is important to teach the mother to care for her infant and to encourage her to become a part of the team.

The nurse also may be involved in a follow-up clinic. Nurses take pride in seeing the later products of the tiny patients they cared for in earlier months. Much can be gained from the follow-up of these high-risk infants.

What about the high-risk nurse of the future? She will continue to grow professionally along with the high-risk nurseries and neonatologists. She will learn new skills including endotracheal intubation. Nurses will continue to be involved in the actual transport of infants and will assume increasing responsibility in this area. The nurse is now an integral part of the "High-Risk Team." Now doctors and nurses work together to give each infant the best possible chance for a meaningful existence. ▲

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# *Doctor's News*

## **Dr. Jirka Wins Two-Year Term As AMA Trustee**

Frank J. Jirka, Jr., M.D., River Forest, was elected to a two-year term as an AMA Trustee during the closing session of the Annual AMA Convention held in Chicago, June 23-27.

Dr. Jirka, a urologist, is an ISMS Past President; delegate to the AMA; and former ISMS Trustee.

Eleven candidates vied for the six positions available on the AMA Board of Trustees.

Also during the AMA meeting, the American Association of Medical Society Executives met at its' annual meeting and elected David Meister, Jr., Peoria to the Board of Directors. Mr. Meister is the county executive for Peoria and Tazwell counties. He has served the counties for many years and is active on the AAMSE committees for continuing education.



*Dr. Jirka*

**CME WORKSHOPS PLANNED FOR THIS FALL**—Continuing Medical Education workshops will be held October 4-6, 1974, in Chicago and St. Louis. Objectives of the workshops are to learn (1) effective methods for involving colleagues in planning and conducting in-hospital CME programs; (2) group techniques for problem-solving; and (3) methods for analyzing the learning needs of hospital colleagues.

The workshops are planned by the Illinois Council on Continuing Medical Education Committee on CME Workshops. The content and approach for the workshop are based on a survey of Illinois hospital CME planners. Fourteen hours of AMA Category I credit may be earned.

For full details, write: Illinois Council on Continuing Medical Education, 360 N. Michigan Ave., Chicago, 60601.

**U. OF I. GETS APPROVAL FOR HOSPITAL**—The Illinois Board of Higher Education recently approved the University of Illinois' plans to construct a \$60 million university hospital on the West Side of Chicago.

The proposed hospital would replace the existing 500-bed university hospital. The project also needs the approval of the General Assembly.

**PHYSICIANS IN THE NEWS**—Robert A. Miller, M.D., pediatric cardiologist, has been appointed Chairman of the Department of Pediatrics of Cook County Hospital, Chicago.

William F. Hejna, M.D., Dean, Rush Medical College and Vice President for Medical Affairs at Rush-Presbyterian-St Luke's Medical Center, has been elected President of the State of Illinois Council of Medical Deans.

The new Dean of the Abraham Lincoln School of Medicine, University of Illinois College of Medicine, is Bernard Sigel, M.D. Dr. Sigel, presently Dean of the Medical College of Pennsylvania, will assume his new position September 1.

ISMS Trustee Warren Tuttle, M.D., Harrisburg, was one of the five University of Illinois College of Medicine graduates to receive Alumni of the Year Awards. Dr. Tuttle was cited for his service to medical organizations.

J. Philip Ambuel, M.D., is the new Medical Director of Ambulatory Services at The Children's Memorial Hospital, Chicago.

Lloyd M. Nyhus, M.D., Professor and Head of the Department of Surgery, Abraham Lincoln School of Medicine, University of Illinois, Chicago, was recently installed as President of the Society for Surgery of the Alimentary Tract.

Beg your pardon—last month's Doctor's News cited Joseph L. Bordenave, M.D., as a recent recipient of a Masters degree in education. This was in error, as Dean Bordeaux, M.D., Peoria, earned this post graduate degree from Bradley University.

#### ISMS Past President Thomsen Honored For 40 Years of Service



In commemoration of 40 years of medical practice, over 800 patients, relatives, associates and friends in general gathered May 31, 1974, to honor Philip G. Thomsen, M.D., Dolton, at a testimonial dinner.

In attendance were Congressman Edward Dworski, former Governor Ogilvie, State Rep. Tom Miller and officials of several south suburban communities as well as the staffs of clinics and hospitals. Congratulatory wires were received from many who could not attend. Both Vice President Gerald Ford and President Nixon sent letters of congratulations.

Dr. Thomsen has been very active in organized medicine having served as President of the Illinois State Medical Society and President of the Illinois Foundation for Medical Care. He presently serves as ISMS Trustee from the Third District.



Dr. Baranov

Mr. Stagl

#### Lester J. Baranov, M.D., Honored

The physicians of Bethesda Hospital, Chicago, paid tribute to Lester J. Baranov, M.D., at a gala State of Israel Bond testimonial dinner last month. Dr. Baranov was cited for his devoted support of Israel's economic development through the State of Israel Bond campaign and for his dedication as a physician.

Guest speaker at the affair was Robert Mayer Evans, foreign correspondent and former Moscow Bureau Chief for CBS news.

Dr. Baranov, a graduate of the Chicago Medical School, was appointed National Surgeon by the Jewish War Veterans of America in 1970.

#### New Head Named For McGaw Medical Center of NU

John M. Stagl, President of Northwestern Memorial Hospital, has been named Executive Vice President of the McGaw Medical Center of Northwestern University. The position became vacant upon the recent death of Ray E. Brown.

Mr. Stagl is a former Trustee of the Illinois Hospital Association, and is Secretary of the Illinois Regional Medical Program and Trustee of the American Hospital Association.

# Editorials



## *Angina Pectoris*

Angina pectoris, a well-known cardiac symptom, is usually ascribed to myocardial ischemia secondary to coronary atherosclerosis. Although one or more of the coronary arteries is narrowed or obstructed, it functions properly so long as the individual is resting or calm. It is during exercise, excitement or, perhaps, following a heavy meal that the blood flow is not adequate. One victim in five goes on to develop coronary thrombosis or myocardial infarction.

The chest pain or feeling of pressure, constriction, or tightness may last seconds or minutes. Nitroglycerin usually brings relief to victims who have only one or two attacks a day. Those with frequent attacks or nocturnal angina should have coronary angiography and aortocoronary bypass surgery. As a rule, the more severe the angina, the better the surgical prospects. Surgical intervention is not recommended when only one vessel is diseased. Angiography requires considerable skill and should be done by technicians and surgeons who do several of these operations every week. Selecting patients for saphenous bypass surgery is not simple. Furthermore several years must elapse before long-term results can be evaluated. Not all bypass grafts remain open. In fact, 15 to 30% of these close. The operative mortality averages six per cent.

The medical treatment of ordinary angina includes nitroglycerin, which not only relieves pain, but is an excellent drug to prevent predictable pain (after meals, or during unpleasant discussions and sexual intercourse). Longer-acting drugs, such as isosorbide dinitrate (Isordil), erythrityl tetranitrate (Cardilate) or pentaerythritol tetranitrate (Peritrate) also may be helpful. Propranolol (Inderal) is useful because it lessens the oxygen needs of the cardiac muscle. Walking a distance shorter than that required to induce pain has a favorable effect on the cardiac contraction.

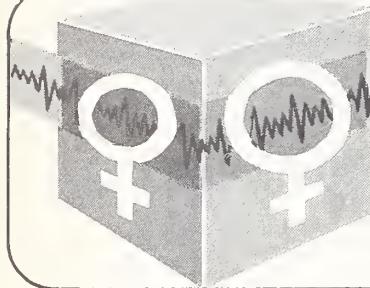
Upper abdominal disorders such as hiatal hernia, peptic ulcer, gallbladder disease, recurrent pancreatic edema often initiate anginal pain at rest in those who also have exertion angina. Reflexes from the abdomen can be very strong and correcting the culprit may be most helpful. The wearing of an abdominal support has long been forgotten, but it may lessen angina in an obese individual.

There are many variations of angina pectoris. Much has been written on the Prinzmetal variant and with the development of bypass surgery for coronary artery disease, the identification of patients with Prinzmetal angina pectoris became more than just academic interest. However, identification is not easy because there is no precise correlation between the clinical picture of Prinzmetal angina and the Underlying anatomy.

Prinzmetal and his group described the variant as 1) Chest pain begins most commonly at rest (often during deep dreamless sleep) or with ordinary activity and not with exertion. 2) During episodes of pain, there is transitory ST elevation on the electrocardiogram which is otherwise normal at rest. 3) Exercise tests are frequently negative. 4) A focal lesion is found in a single vessel only. 5) During pain, arrhythmias, such as ventricular tachycardia or conduction disorders are frequently noted. 6) Myocardial infarction often occurs in the area of the heart corresponding to the ST segment elevation. 7) Finally, there is no subsequent serum enzyme elevation.

There is little coronary atherosclerosis, minimal plaquing with no areas of narrowing greater than 20%, or entirely normal coronary arteries. Perhaps the coronary artery spasms are responsible for the distress. In fact, well-defined spasms have been observed during angiography. Chest pain also has been brought on or aggravated by

(Continued on page 62)



## pulse... of the doctor's wife

MRS. HAROLD KEEGAN, Editor

### As I Saw It.... In Springfield

One persistent thought emerged during and after the ISMS LEGISLATION DAY in Springfield, and it overwhelms every other impression and expression from the day: WE MUST BECOME INVOLVED! And it is imperative that we convince our physician husbands to take the time not only to be informed but to let their voices be heard LOUD AND CLEAR IN GOVERNMENT!

Yes, I'm well aware how busy they are and that they must take care of the sick and wounded first . . . but bills are being enacted every session that limit their effectiveness in practicing medicine. These new laws tend to add more and more paper work plus more restrictions on the "art of medicine."

Listening to the governor, I thought to myself "He really doesn't understand the practice of medicine nor does he realize what is being done to medicine through all the limitations being imposed on physicians through bureaucies."

Each speaker, even though some were eloquent, made the picture even more clear! POLI-

TICS IS NOT SOMETHING WE CAN LEAVE TO THE PROFESSIONAL POLITICIANS. We as doctors' wives must take an active interest and do something to encourage good legislation. We can be effective! It is so easy to excuse our lack of action because we are busy . . . but we no longer can afford to neglect our responsibility.

Won't you please read the ISMS *Action Report* and *On the Legislative Scene*? They are sent to you without charge. If you are not already receiving them, write the ISMS office to put you on the mailing list. NOW, after you read the issues currently before the legislature. DO WRITE YOUR REPRESENTATIVES AND SENATORS TO EXPRESS YOUR VIEWS. Let them know how you feel, how you want them to represent you! They do read their mail and letters are effective. When it comes time to vote, support those who are friends of medicine and who can best represent us and do what is right for our state and our nation.

Millie Vickery, President-Elect  
WA/ISMS

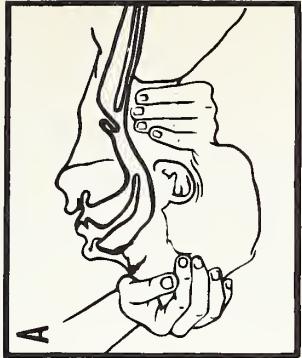
### District Meetings

|              |                |             |                       |
|--------------|----------------|-------------|-----------------------|
| September 10 | District 4     | Rock Island | Place to be announced |
| September 17 | District 5 & 6 | Pekin       | Pekin Country Club    |
| September 19 | District 1 & 2 | Elgin       | Holiday Inn           |
| September 27 | District 11    | Joliet      | Place to be announced |

# MOUTH-TO-MOUTH RESUSCITATION

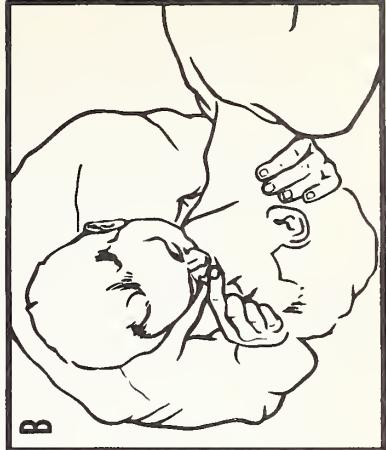
## A. — AIRWAY

1. Clear the Mouth.
2. Lift Neck so the Head is Tilted Back.
3. Push or Pull Jaw into a Jutting Out Position.



## B. — BREATHING

4. Pinch Nose SHUT.
5. Cover victim's Mouth with Your Mouth. BLOW until Chest Rises:  
**For BABIES:** Cover Mouth and Nose.
6. Remove your mouth. Listen for return air.  
Repeat 12 to 15 Times per Minute.



WOMAN'S AUXILIARY TO THE ILLINOIS STATE MEDICAL SOCIETY

The Woman's Auxiliary to the Illinois State Medical Society are selling these "Mouth-to-Mouth Resuscitation" plaques. Inquiries in obtaining these plaques should be directed to: Mrs. Paul E. Wochos, WA/ISMS Safety Chairman, 349 S. Elmwood Lane, Plum Grove Estates, Palatine, Ill. 60067.

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
360 No. Michigan Ave. • Chicago, IL 60601 • (312) 782-1654



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events.

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## AUGUST

### Emergency Care

#### EMERGENCY MEDICAL CARE

For: All physicians. August 12-16, 1974; Wisconsin Ctr., Madison, Wis. Sponsor, contact: Univ. of Wisconsin, Dept. of Continuing Med. Educ., 610 N. Walton St., Madison, WI 53706.

### Family Medicine

#### SPECIALTY REVIEW COURSE FOR FAMILY MEDICINE

For: Family Physicians. 10½-day course, August 12-23, 1974, Chicago. Hrs. of Instr.: 98. CME Credit: AMA Category 1. Fee: \$300. Reg. Limit: 150. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

### General Interest

#### PAS & MAP TUTORIAL SESSION

For: Physicians, Hosp. Admin., Allied Health. August 7-8, 1974, Ann Arbor, Mich. Hrs. of Instr.: 12. CME Credit: AMA Category 1. Fee: \$110 (1-4 persons, if at least 2 physicians). Reg. Limit: 75. Sponsor, contact: Commission on Professional & Hosp. Activities, 1968 Green Rd., Ann Arbor, MI 48105.

### Orthopaedics

#### SPECIALTY REVIEW COURSE IN ORTHOPAEDICS

For: Specialists. 6½-day course, August 25-31, 1974, Chicago. Hrs. of Instr.: 60. CME Credit: AMA Category 1. Fee: \$200. Reg. Limit: 60. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

### Psychiatry

#### WINNEBAGO SYMPOSIUM FOR GENERAL PRACTITIONERS

For: Family Physicians. August 22, 1974, The Pioneer Inn, Oshkosh, Wis. Hrs. of Instr.: 6. CME Credit: AMA Category 1. Fee: \$15. Reg. Limit: 60. Sponsor, contact: Winnebago State Hospital, Box H, Winnebago, WI 54985.

### Sports Medicine

#### SPORTS MEDICINE

For: Family Physicians, Allied Health. One-day workshop, August 28, 1974, Indianapolis. Hrs. of Instr.: 7. CME Credit: AMA Category 1. Sponsor, contact: Mr. John Roscoe, Program Co-ord., Indiana Univ. Sch. of Med., 1100 W. Michigan, Indianapolis, IN 46202.

## SEPTEMBER

### Alcoholism

#### ALCOHOLISM

For: All Physicians, Allied Health. Weekly medical education seminar, Sept. 24, 1974, 11:30 AM, Memorial Hospital of DuPage County, Elmhurst, Ill. Speaker: Herbert Neuhaus, M.D., Dept. of Public Health Hosp., Chicago. Hrs. of Instr.: 1. CME Credit: AMA Category 1. Sponsor, contact: John H. Huss, M.D., DME, Memorial Hospital of DuPage County, Avon Rd. & Schiller St., Elmhurst, IL 60126.

### Anesthesiology

#### CLINICAL ANESTHESIA PRACTICE—COURSE I

For: All Physicians. 1-month course, Sept. 30-Oct. 29, 1974, Chicago. Hrs. of Instr.: 176 approx. CME Credit: AMA Category 1. Fee: \$400. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

### Cardiology

#### CARDIOVASCULAR DISEASES

For: All physicians. Lecture, group discussion, Sept. 13, 10 AM, S.R. Forkosh Hospital; Sept. 13, 6 PM, Lincolnwood Hyatt House; Sept. 14, 10 AM, Bethany Methodist Hospital. Speaker: G. T. Gau, M.D., Mayo Clinic. CME Credit: 5 hrs. AMA Category 1. Fee: \$10 (non-staff, for dinner). Reg. Deadline: Sept. 9, 1974. Sponsor: FAB-CME. Contact: Mr. S. Plotner, S. R. Forkosh Hospital, 2544 W. Montrose, Chicago, IL 60618; (312) 267-2200.

#### INTERNATIONAL SYMPOSIUM ON EPIDEMIOLOGY OF HYPERTENSION

For: All Physicians, Epidemiologists. 3-day symposium, Sept. 18-20, 1974, Sheraton-Blackstone Hotel, Chicago. Fee: \$150 (\$75 students). Sponsor, contact: Helen Heck, Chicago Heart Association, 22 W. Madison St., Chicago, IL 60602.

#### INTERMEDIATE CARDIOLOGY

For: All Physicians. 4½-day course, Sept. 23-27, 1974, Chicago. Hrs. of Instr.: 32 approx. CME Credit: AMA Category 1. Fee: \$175. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

#### ECHOCARDIOGRAPHY WORKSHOP

For: Specialists. 4-day course, Sept. 30-Oct. 3, 1974, Indianapolis. Hrs. of Instr.: 28. CME Credit: AMA Category 1. Reg. Limit: 50. Sponsor, contact: Mr. John Roscoe, Program Co-ord., Indiana Univ. Sch. of Med., 1100 W. Michigan, Indianapolis 46202.

### Family Medicine

#### FIFTH FAMILY MEDICINE REVIEW

For: Family Physicians, Osteopaths. Symposium, Sept. 15-21, 1974, Univ. of Kentucky Medical Ctr., Lexington, Ky. CME Credit: 50 hrs. AAFP; 50 hrs. AMA Category 1. Fee: \$195. Reg. Limit: 250. Sponsor, contact: Ofc. of Cont. Educ., College of Med., Univ. of Kentucky, Lexington, KY 40506.

### Gastroenterology

#### UPPER GASTROINTESTINAL ENDOSCOPY

For: Specialists. 2-week course, Sept. 9-20, 1974, Chicago. Hrs. of Instr.: 40 approx. CME Credit: AMA Category 1. Fee: \$350. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

#### FIBEROPTIC COLONOSCOPY

For: All Physicians. 3-day course, Sept. 11-13, 1974, Chicago. Hrs. of Instr.: 21 approx. CME Credit: AMA Category 1. Fee: \$250. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

#### FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY

For: Specialists. 3-day course, Sept. 16-18, 1974, Chicago. Hrs. of Instr.: 20 approx. CME Credit: AMA Category 1. Fee: \$250. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

### Internal Medicine

#### REVIEW COURSE IN RHEUMATOLOGY

For: Family Physicians. 1-week course, Sept. 9-13, 1974, Chicago. Hrs. of Instr.: 35 approx. CME Credit: AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

#### REVIEW COURSE IN PULMONARY

For: Family Physicians. 1-week course, Sept. 9-13, 1974, Chicago. Hrs. of Instr.: 35 approx. CME Credit: AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

#### RECENT CONCEPTS IN DIABETIC MANAGEMENT

For: All Physicians, Allied Health. Weekly medical education seminar, Sept. 10, 1974, 11:30 AM, Memorial Hospital of DuPage County, Elmhurst, Ill. Speaker: Ann M. Lawrence, M.D., Univ. of Chicago. Hrs. of Instr.: 1. CME Credit: AMA Category 1. Sponsor, contact: John H. Huss, M.D., DME, Memorial Hospital of DuPage County, Avon Rd. & Schiller St., Elmhurst, IL 60126.

#### ENDOCRINOLOGY

For: Internists. 3-day course, Sept. 11-13, 1974, Hilton Hotel, Indianapolis. Hrs. of Instr.: 18. CME Credit: AMA Category 1. Sponsor, contact: American Coll. Physicians, 4200 Pine St., Philadelphia 19104.

#### REVIEW COURSE IN HEMATOLOGY

For: Family Physicians. 1-week course, Sept. 30-Oct. 4, 1974, Chicago. Hrs. of Instr.: 35 approx. CME Credit: AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

#### REVIEW COURSE IN INFECTIOUS DISEASES

For: Family Physicians. 1-week course, Sept. 30-Oct. 4, 1974, Chicago. Hrs. of Instr.: 35 approx. CME Credit: AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

#### REVIEW COURSE IN NEPHROLOGY

For: Family Physicians. 1-week course, Sept. 30-Oct. 4, 1974, Chicago. Hrs. of Instr.: 35 approx. CME Credit: AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

### Neurology

#### SPECIALTY REVIEW IN NEUROLOGY—PART II, CLINICAL

For: All Physicians. 1-week course, Sept. 9-13, 1974, Chicago. Hrs. of Instr.: 44 approx. CME Credit: AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

#### Obstetrics/Gynecology

#### BASIC GYNECOLOGY

For: All Physicians. 1-week course, Sept. 16-20, 1974, Chicago. Hrs. of Instr.: 35 approx. CME Credit: AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

#### GYNECOLOGICAL LAPAROSCOPY

For: Specialists. 1-week course, Sept. 23-27, 1974, Chicago. Hrs. of Instr.: 15 approx. CME Credit: AMA Category 1. Fee: \$250. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

## *Occupational Medicine*

### **34TH CONGRESS ON OCCUPATIONAL HEALTH**

For: Industrial Physicians, Nurses, & Safety Engineers. Symposium-workshop, Sept. 9-10, 1974, Marriott Motor Hotel, Chicago. CME Credit: 12 hrs. AMA Category 1. Fee: \$20. Sponsor, contact: Henry F. Howe, M.D., AMA Dept. of Environmental, Public, & Occupational Health, 535 N. Dearborn St., Chicago, IL 60610. Co-sponsor: Nat'l Institute for Occupational Safety & Health, U.S. Dept. of HEW.

## *Ophthalmology*

### **OPHTHALMOLOGY**

For: All Physicians. 2-day seminar, Sept. 6-7, 1974, Wisconsin Center, Madison, Wis. Sponsor, contact: Dept. of Cont. Med. Educ., Univ. of Wisconsin Med. Sch., 610 Walnut St., Madison, WI 53703.

## *Pediatrics*

### **COMPREHENSIVE CHILDHOOD TRAUMA SYMPOSIUM**

For: All Physicians. 2-day symposium, Sept. 11-12, 1974, Stouffer's Inn, Indianapolis. Hrs. of Instr.: 14. CME Credit: AMA Category 1. Sponsor, contact: Mr. John Roscoe, Program Co-ord., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

### **PROBLEMS IN PEDIATRIC UROLOGY MANAGEMENT**

For: All Physicians. One-day workshop, Sept. 25, 1974, Indianapolis. Hrs. of Instr.: 7. CME Credit: AMA Category 1. Sponsor, contact: Mr. John Roscoe, Program Co-ord., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

## *Plastic Surgery*

### **REVIEW COURSE IN PLASTIC SURGERY**

For: Plastic Surgeons. 3-day lecture series, Sept. 3-5, 1974, McGraw Med. Ctr., Northwestern Univ., Chicago. Hrs. of Instr.: 18½. Fee: \$200. Reg. Deadline: July 31, 1974. Sponsor: Dept. of Surgery, Northwestern Univ. Med. Sch. Contact: D. A. Keranahan, M.D., Childrens Memorial Hospital, 2300 Childrens Plaza, Chicago, IL 60614.

### **MANAGEMENT OF INDUSTRIAL INJURIES OF THE HAND**

For: Family Physicians, Plastic Surgeons. Symposium, Sept. 14, 1974, Barnes Hospital, St. Louis. Sponsor, contact: Paul M. Weeks, M.D., Director, Milliken Hand Rehab. Ctr., 907 Wohl Clinic, 4960 Audubon Ave., St. Louis, MO 63110. Co-sponsor: Washington Univ. Sch. of Med.

## *Psychiatry*

### **CURRENT & FUTURE PERSPECTIVES IN TREATMENT OF ALCOHOLISM**

For: All Physicians. Lecture, Sept. 18, 1974, 7:30 PM, Forest Hosp. Professional Ctr., Des Plaines, Ill. Speaker: R. J. Catanzaro, M.D., The Palm Beach Institute, Florida. Fee: \$15 (\$5 students). Sponsor, contact: Forest Hospital, 555 Wilson Lane, Des Plaines, IL 60016; (312) 827-8811, ext. 362.

## *Radiology*

### **GAMMA SCINTILLATION CAMERA WORKSHOP**

For: Specialists. 3-day workshop, Sept. 5-7, 1974, Indianapolis. Hrs. of Instr.: 21. CME Credit: AMA Category 1. Reg. Limit: 30. Sponsor, contact: Mr. John Roscoe, Program Co-ord., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

## *Surgery*

### **MANAGEMENT OF COMPLICATIONS IN SURGERY**

For: All Physicians. 4-day course, Sept. 16-19, 1974, Chicago. Hrs. of Instr.: 28 approx. CME Credit: AMA Category 1. Fee: \$175. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

### **UPPER MIDWEST REVIEW OF GASTROENTEROLOGY**

For: All Physicians. 1½-day lecture & discussion, Sept. 21-22, 1974, Pfister Hotel, Milwaukee. CME Credit: 10 hrs. AAFP. Fee: \$125. Sponsor, contact: The Medical College of Wisconsin, c/o A. T. Finnegan, Course Coord., 561 N. 15th St., Milwaukee, WI 53233.

### **FLUID & ELECTROLYTE MANAGEMENT**

For: All Physicians. 1-week course, Sept. 23-27, 1974, Chicago. Hrs. of Instr.: 30 approx. CME Credit: AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

### **BRONCHOSCOPY**

For: Specialists. 1-week course, Sept. 23-27, 1974, Chicago. Hrs. of Instr.: 20 approx. CME Credit: AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

### **DISEASES OF ESOPHAGUS, STOMACH & DUODENUM**

For: All Physicians. 3-day course, Sept. 26-28, 1974, Chicago. Hrs. of Instr.: 20 approx. CME Credit: AMA Category 1. Fee: \$125. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

## *Neurology*

### **3RD ANNUAL CHILD NEUROLOGY SOCIETY MEETING**

For: Pediatric Neurologists. Annual meeting, Oct. 10-12, 1974, Hilton Hotel, Madison, Wis. Sponsor, contact: Child Neurology Society, Box 486 Mayo, 412 Southeast Union, Minneapolis, Minn. 55455.

## *Obstetrics-Gynecology*

### **SPECIALTY REVIEW IN OB-GYN**

For: Specialists. 2-week course, Oct. 28-Nov. 8, 1974, Chicago. CME Credit: 86 hrs. (approx.) AMA Category 1. Fee: \$350. Reg. Limit: 85. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

## *Orthopaedics*

### **MANAGEMENT OF COMMON FRACTURES**

For: Family Physicians. 1-week course, Oct. 28-Nov. 1, 1974, Chicago. CME Credit: 30 hrs. (approx.) AMA Category 1. Fee: \$200. Reg. Limit: 30. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

## *Otolaryngology*

### **OTOLARYNGOLOGY WORKSHOP**

For: Family Physicians. Seminar, Oct. 30, 1974, Indianapolis. CME Credit: 7 hrs. AMA Category 1. Sponsor, contact: Mr. John Roscoe, Program Co-ord., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

## *Pediatrics*

### **MANAGEMENT OF PEDIATRIC HEART DISEASE**

For: All Physicians. 3-day course, Oct. 30-Nov. 1, 1974, Chicago. CME Credit: 21 hrs. (approx.) AMA Category 1. Fee: \$100. Reg. Limit: 45. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

## *Psychiatry*

### **PSYCHIATRY FOR THE MEDICAL PRACTITIONER**

For: All Physicians. 4-day course, Oct. 7-10, 1974, Chicago. CME Credit: 24 hrs. (approx.) AMA Category 1. Fee: \$175. Reg. Limit: 80. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

### **CURRENT & FUTURE PERSPECTIVES IN DRUG ABUSE**

For: All Physicians. Lecture, Oct. 16, 1974, 7:30 PM, Forest Hospital Professional Ctr., Des Plaines, Ill. Speaker: P. G. Bourne, M.D., Special Action Ofc. for Drug Abuse Prevention, Washington, D.C. Fee: \$15 (\$5 students). Sponsor, contact: Forest Hospital, 555 Wilson Lane, Des Plaines, IL 60016; (312) 827-8811, ext. 362.

### **PSYCHOPHARMACOLOGY**

For: Family Physicians, Specialists. Seminar, Oct. 16, 1974, Indiana Univ. N.W. Campus, Merrillville, Ind. CME Credit: 6 hrs. AMA Category 1. Sponsor, contact: Mr. John Roscoe, Program Co-ord., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

### **PSYCHIATRY FOR THE ADOLESCENT**

For: All Physicians. Lecture, group discussion, Oct. 23, 1974, 10 AM, Bethany Methodist Hosp.; Oct. 23, 6 PM, Lincolnwood Hyatt House; Oct. 24, 10 AM, Belmont Hosp. Speaker: Beverley Mead, M.D., Dept. of Psychiatry, Creighton Univ. Sch. of Med. CME Credit: 5 hrs. AMA Category 1. Fee: \$10 (non-staff, for dinner). Reg. Deadline: Oct. 18, 1974. Sponsor: FAB-CME. Contact: Mr. D. Larson, Bethany Methodist Hosp., 5025 N. Paulina, Chicago, IL 60640; (312) 271-9040.

## *Radiology*

### **DIAGNOSTIC RADIOLOGY**

For: Family Physicians. 1-week course, Oct. 7-11, 1974, Chicago. CME Credit: 35 hrs. (approx.) AMA Category 1. Fee: \$200. Reg. Limit: 25. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

## *Surgery*

### **PRE & POSTOPERATIVE CARE OF PATIENTS**

For: Surgeons, Surgical Specialists. 4-day course, Oct. 29-Nov. 1, 1974, Chicago. CME Credit: 32 hrs. (approx.) AMA Category 1. Fee: \$175. Reg. Limit: 80. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

## *Urology*

### **SPECIALTY REVIEW—UROLOGY**

For: Specialists. 3½-day course, Oct. 2-5, 1974, Chicago. CME Credit: 30 hrs. (approx.) AMA Category 1. Fee: \$150. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

**Abstracts of the Board**  
(Continued from page 23)

AMA House those resolutions which favor repeal of PSRO and are consistent with the position taken by the ISMS House of Delegates in this matter.

**Support Anesthesiologists**

The Board agreed to support the position of the Illinois Society of Anesthesiologists in the matter of licensing requirements for Ambulatory Surgical Treatment Centers. The following was approved: "A licensed physician, or a certified registered nurse anesthetist medically directed by a licensed physician, who has privileges to administer or direct the administration of anesthesia in a hospital accredited by the Joint Commission on Accreditation of Hospitals, shall be present for the administration of anesthetics and recovery of patients. The approved program for the facility shall include policies regarding the provision of anesthesia services."

**Council and Committee Appointments**

In the future, county societies will be invited to submit nominations for ISMS council and committee appointments. Until now, only officers and trustees have been asked for nominations, with the Board as a whole approving the slate of each council and committee. Letters of appointment for 1974-75 committees are in the mail.

**Membership Recruitment**

The Board commended the Public Relations Council for its recognition of the importance of internal communications with members, but referred back to the council its membership recruitment campaign plan. The Board said that some parts of the program required further study regarding feasibility.

**Recognition of SIMA 100th Anniversary**

ISMS will present an appropriate plaque to the Southern Illinois Medical Association in honor of SIMA's 100th anniversary.

**MEDICHEK**

As a follow-up to Resolution 74M-25, which called for clarification and modification of MEDICHEK regulations, the Governmental Health Program Reimbursement Committee informed the Board it had met with representatives of the Illinois Departments of Public Health and Public Aid to discuss the four parts of the resolution.

A. Because federal regulations mandate the implementation of MEDICHEK throughout the country, the Board recognized the impracticality of requiring its annual approval by county medical societies.

B. The committee reported that the federal MEDICHEK program could not be under the "direct control of the peer review and ethical relations committees of the local county medical society," as specified in the resolution but that state officials welcomed review and comment from these sources. The Board instructed the committee to seek a stronger commitment from state officials and continue its dialogue with them in this area.

C. The committee's recommendation that physicians be encouraged to charge usual and customary fees for services under MEDICHEK was approved by the Board, and the committee was instructed to obtain a firm commitment from the Department of Public Aid that the present maximum fee schedule would be reviewed and adjusted accordingly at the end of six months.

D. It was reported that the pilot projects referred to in the resolution were already operating and no further action needed.

In a related action, the Board commended Joel Edelman, Director of the Department of Public Aid, for his efforts to keep confidential the record of IDPA payments to individual physicians preventing such data from being sensationalized in the public press.

## **Problems of Pharmaceutical Industry**

The Board directed the Executive Committee to assign to an appropriate ISMS committee the problem of bureaucratic intervention in the pharmaceutical industry and to study generic vs. brand name prescribing with a view toward developing a position for ISMS to take in this matter.

## **Peer Review Appeals**

A question involving the right of insurance carriers to utilize the ISMS peer review process was resolved by referring to the following bylaws statement: "Any party to the proceedings considering himself aggrieved by the findings and recommendations of the (local) committee shall have the right to appeal through the component society to the Illinois State Medical Society."

## **Psychotherapy Definition**

In keeping with House Action, the Board approved and referred to the Policy Committee the following definition:

Medical Psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal or non-verbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches, who has had training in psychiatric medicine.

## **Mental Health Department Budget**

At the request of the Council on Mental Health and Addiction, the Board directed the Governmental Affairs Council to take appropriate action toward increasing the Illinois Department of Mental Health budget so that \$5 million would be available for the purchase of care for mental treatment in licensed private psychiatric facilities.

## **Proposed Mental Health Department Rules**

ISMS will object to the Mental Health Department's proposed Rule 12.09, which outlines the procedure to be followed for administering psychotropic drugs in state facilities. The department will be asked to delay implementation until the council has had an opportunity to review and comment on proposed rules.

## **Revision of Mental Health Code**

Noting the need for physician guidance in the proposed revision of the Illinois Mental Health Code, the Board will urge ISMS members to send their suggestions for code changes to the state medical society for forwarding to the Revision Committee.

## **Other Legislation**

On recommendation of the Medical Legal Council, the Board rescinded its previous endorsement of HB 751, the Clinical Research Act, because of amendments and changes being contemplated by the legislature. ISMS will now oppose the bill in its present form and referred the matter back to the Medical Legal Council to develop appropriate amendments.

The Board also referred to the Governmental Affairs Council a recommendation that ISMS support HB 2571, which would amend the Controlled Substances Acts, and HB 2826, which would create a Dangerous Drug Commission.

The Board also:

Will not endorse HB 2225, the Comprehensive Health Service Act unless appropriately amended;

Not support proposed legislation rescinding exemption, for religious beliefs, from mandatory immunizations and other mandatory medical procedures;

Oppose HB 2217, which would create a new class of crimes related to controlled substances;

Referred to the Executive Committee a recommendation to oppose HB 2710, which

would require legislative approval for the closing or reducing of programs in state mental hospitals.

Oppose HB 1412, Nursing Practice Act amendment, until the Joint Practice Committee has taken a position on it:

Support HB 2757, the Health Professional Student Loan Program, if ISMS amendments are accepted by the sponsor;

Vigorously oppose SB 1500, which would grant permanent limited licenses to hospital permit physicians under certain conditions.

### **Plan for Perinatal Health**

On recommendation of the Council on Environmental and Community Health, the Board endorsed the final version of a Plan for Perinatal Health in Illinois. The council stated that implementation of the plan will result in improved care for both the high-risk mother and high-risk infant.

### **Proposed Rules for Sodium, Nitrate and Nitrite Content in Drinking Water Supplies**

The Board endorsed the Illinois Environmental Protection Agency's proposed rules for sodium, nitrate and nitrite content in drinking water supplies. The new standards update present Illinois standards and bring them into line with federal guidelines.

### **Health Care Delivery Problems in Spanish-Speaking Communities**

The Board approved a recommendation of the Council on Social and Medical Services that ISMS, in collaboration with local medical societies, explore the possibility of sponsoring conferences for health care providers and agencies located in predominantly Spanish-speaking neighborhoods.

### **Guidelines for Weight Reduction Programs**

As a follow-up to approving a position statement on the use of human chorionic gonadotropin in weight reduction, the Board endorsed a set of "Guidelines in the Selection of a Weight Reduction Program." The guidelines are to be submitted to the Illinois Osteopathic Association for its consideration and possible co-sponsorship, since there are osteopaths being employed by weight clinics.

The Board also agreed that the guidelines be given wide public distribution via the mass media, that they be reproduced on appropriate-sized cards for distribution to patients in physicians' offices and other health facilities, that they be made available to the AMA Council on Foods and Nutrition, and that the ISMS work with the Illinois Department of Public Health in exploring the need for regulating weight control businesses in Illinois. (Guidelines appear on page 19.)

### **Professional Liability in Patient Care**

The Medical Legal Council was authorized to begin development of a revised version of the "Physician's Liability in Patient Care" booklet, with production costs allocated from the council's budget. Legal counsel will review materials before they are published.

### **Special Advisory Committee to IDPH**

A proposal to develop a special Legislative Advisory Committee to Illinois Public Health Director Joyce Lashof has been referred to the Executive Committee, which will consult with the Illinois Hospital Association and others interested in establishing this committee. The Governmental Affairs Council recommended to the Board that existing ISMS councils and committees be utilized rather than another advisory committee.

### **Legislative Seminar**

The Public Affairs Committee will sponsor a Legislative Seminar September 20-22 at Chateau Louise in Dundee. Invitations will be mailed to 3,500 physicians and spouses on the mailing list for On the Legislative Scene. Information group discussions on the legislative process are planned, with legislators serving as faculty and physicians as students. ▲

## **Swimming Instructions for Pre-School Children**

(Continued from page 27)

Pediatricians do not claim to be experts on swimming or swimming instruction, but they will justifiably claim to be experts on child development. They also will claim a better perspective, a broader view of the child in the longitudinal consequences of various pressures and influences on his emotional integrity. We are a success oriented society with ever-decreasing ability to delay the gratification of success. The child's best interests must always be paramount in all programs aimed at making him perform or excel. ▶

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### **Swimming Safety**

As the outdoor swimming season approaches, the safety experts predict with certainty that some thousands of Americans will drown in the coming summer months.

They will drown in swimming pools, in lakes and streams, at ocean beaches. Some will drown while in for a refreshing dip and others will fall out of boats and off docks and piers.

Many, if not most, of these drownings need not happen.

The American Medical Association offers some basic safety rules that can help to avoid a tragic water accidents.

- Learn to swim and to relax in the water.
- Never swim alone.
- Do not swim when overly tired or when the water is extremely cold.
- Do not overestimate your ability and endurance.
- Swim at protected pools or beaches under the supervision of a trained lifeguard.
- If a boat overturns, stay with it and don't try to swim a long distance to shore.
- Never dive into water of unknown depth.
- Try new activities, such as water skiing or scuba diving, only after learning the skills from qualified instructors.

Many families will do most of their swimming this season in private pools, in their own backyards or in those of a friend or neighbor. There also are some special safety precautions for private pools.

- Make certain the pool is kept clean and the water chemically purified.
- Walk, don't run, about the pool. Horseplay is dangerous.
- Fence the pool and keep the gate locked to keep out small children.
- Keep handy rescue equipment, such as long poles and ring bouys.
- Keep bottles and glasses away from the concrete or metal pool deck.

## **EKG of the Month**

(Continued from page 45)

Answers: 1. D. 2. E. The rhythm strip shows SA block with short pauses. These should not be confused with non-conducted premature atrial beats followed by an incomplete compensatory pause. No premature p waves can be seen. During monitoring long pauses were documented that probably produced the syncope. Other mechanism in patient on thioridazine and chlorpromazine is ventricular tachycardia and fibrillation. This was not seen. Serum lithium level was 2.5 mEq/L (therapeutic range 0.5 to 1.5 mEq/L). Patient refused pacemaker. Isoproterenol was started.

Patient improved and SA block disappeared with decreasing lithium levels only to reappear when drug was restarted. Most frequent causes of SA block include drug toxicity (digitalis, quanidine, and potassium salts), acute myocarditis, and myocardial ischemia. Since our patient had no other cause for the block, but had high lithium levels, the possibility of lithium induced SA block is raised. ▶

### **COOK COUNTY**

#### **Graduate School of Medicine**

CONTINUING EDUCATION COURSES

STARTING DATES, 1974

SPECIALTY REVIEW FOR FAMILY PRACTICE, August 12  
SPECIALTY REVIEW IN ORTHOPAEDICS, August 25  
SPECIALTY REVIEW COURSES IN PULMONARY & RHEUMATOLOGY, September 9  
SPECIALTY REVIEW COURSES IN HEMATOLOGY, INFECTIOUS DISEASES & NEPHROLOGY, Sept. 30  
SPECIALTY REVIEW IN SURGERY, PART I, Sept. 30  
SPECIALTY REVIEW IN OBSTETRICS & GYNECOLOGY, Oct. 28  
SPECIALTY REVIEW IN MEDICINE, RECERTIFYING, Oct. 14  
SPECIAL COURSE IN GYNECOLOGIC PATHOLOGY, Oct. 14  
MANAGEMENT OF COMPLICATIONS IN SURGERY, 4 Days, Sept. 16  
MANAGEMENT OF COMMON FRACTURES, One Week, Oct. 28  
FLUIDS & ELECTROLYTES, One Week, Sept. 23  
BASIC GYNECOLOGY, One Week, September 16  
BASIC ELECTROCARDIOGRAPHY, One Week, Oct. 28  
INTERMEDIATE CARDIOLOGY, September 23  
NEUROLOGY, PART II, CLINICAL, One Week, September 9  
PSYCHIATRY FOR THE MEDICAL PRACTITIONER, 4 Days, Oct. 7  
STATE & NATIONAL BOARD REVIEW, Basic & Clinical, Oct. 14 & 20

*Information concerning numerous other continuation courses available upon request.*

Address:

REGISTRAR, 707 South Wood Street,  
Chicago, Illinois 60612

## The Cholesterol Hypothesis and the Coronary Primary Prevention

(Continued from page 30)

7. Leren, P.: "The Effect of Plasma Cholesterol Lowering Diet in Male Survivors of Myocardial Infarction." *Acta Med. Scand. Suppl.* 466:48-92, 1966.
8. Leren, P.: "The Oslo Diet-Heart Study. Eleven-Year Report." *Circulation* 40:935-942, 1970.
9. "Report of a Research Committee to the Medical Research Council: Controlled Trial of Soya-Bean Oil in Myocardial Infarction," *Lancet*, II:693-699, 1968.
10. Olson, R. E.: Prevention and Control of Chronic Disease: 1. "Cardiovascular Disease—With Particular Attention to Atherosclerosis." *Amer. J. Pub. Health* 49:1120-1128, 1959.
11. *Protocol for the Lipid Research Clinics Type II Coronary Primary Prevention Trial*. April, 1973.

### EDITORIAL: Angina Pectoris

(Continued from page 53)

such drugs as guanethidine, alpha-methyldopa, and propranolol. The spasms may respond to nitroglycerin.

Spasm appears to be the logical cause but not all cardiologists consider this a satisfactory explanation. In addition, there is no standard remedy, except when medical therapy is not effective, a surgical approach should be attempted. Various methods have been tried. Those with no significant coronary disease as shown on the angiograph do well on nitroglycerin and sublingual isosorbide.

T. R. Van Dellen, M.D.  
Editor

### References

1. "Prinzmetal Variant of Angina Pectoris.", Editorials, *JAMA* 228:3 (April 15) 1974.
2. "Prinzmetal Variant Angina Covers a Wide Spectrum." *Internal Medicine News* (April 1) 1974.

## LOW-COST GROUP INSURANCE ANOTHER **ISMS** MEMBERSHIP PRIVILEGE

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FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:



9933 N. Lawler Avenue  
Skokie, Illinois 60076  
Phone: 312-679-1000

Central Illinois Service Office: 849 Forest Lane—Petersburg, Ill. 62675 • phone 217-632-7220  
Wayne J. Hubbert, District Manager

# Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

**ALEDO:** Mercer County, 17,000 population, needs additional family physicians. 4 active physicians at present. General acute hospital in Aledo. High quality medical care economically rewarding. Thirty miles from metropolitan quad-city area. Good small community for family living. Contact: Shirley Lindberg or Monty McClellan, M.D., 308 NW Fourth Street, Aledo, 61231, 309/582-5156. (10)

**BLOOMINGTON:** General Practitioners, Internists, Pediatricians and a Surgeon needed to help establish a multi-specialty clinic in a new Erdman Building. Corporate practice with all the usual benefits. Contact: Paul G. Theobald, M.D., #1 Medical Hills Dr., Bloomington, 61701, 309/828-6051. (10)

**CHAMPAIGN:** Private hospital expanding and building new 110 bed facility. We are seeking a General Surgeon, Internist and Family Practitioner. Minimum guarantee offered. Contact: Donald L. Francis, Executive Director, Cole Hospital, Inc., 809 W. Church Street, Champaign, 61820; (217) 356-3788. (8)

**CHARLESTON:** Small midwestern University Health Service serving 8,000 students, 4½ day week; no after hours or weekends. Perfect for post-retirement. Five weeks vacation and one week for medical meetings. Life insurance, health insurance, and University Retirement System. Contact: Director, Health Service, Eastern Illinois University, Charleston, 61920, (217) 581-3013. (10)

**CHENOA:** Rural area, 100 miles south of Chicago on I-55. Looking for one or two physicians to do family practice. Hospital facilities nearby. Financial assistance and office space can be arranged. Contact: R. J. Walker, National Bank of Chenoa, Chenoa, 61726, 815-945-2311. (10)

**CHICAGO:** Private young multispecialty group seeks General Practitioners or Medical Specialist. University affiliation available. Spanish speaking M.D. welcomed. Contact: Dr. Finley W. Brown or Dr. Gonzalo Ruiz, 3109 W. Armitage, Chicago, 60647, 312-276-8811. (7)

**CHICAGO:** Generalist or Internist wanted for full-time practice in welfare neighborhood. New office, unlimited financial opportunity. For details contact: Mrs. Grescio, Dr. G. Mizock Office, 6201 N. California, Chicago 60645. 312-642-1094 (8)

**CHICAGO & SUBURBS:** Privately owned multispecialty clinic, 40-48 hour week. Day and/or night work. Contact: Joseph Lentini, Garfield Medical Center. (312) 624-4200 or (312) 427-3343. (8)

**CHICAGO:** Board Certified or eligible, Internal Medicine, Illinois Registration. Medical Center, providing preventive and therapeutic medical care with other specialists and diagnostic services on premises. Administrative Ability an Asset, Salary Open, Commensurate with background and experience. Call Collect: William A. Hutchison, M.D., Union Medical Center, 1657 West Adams, Chicago, 60612, (312) 829-1134. (10)

**CREVE COEUR:** M.D. URGENTLY NEEDED as an associate in a very active practice in the Peoria area. hospitals. Present M.D. wishes to retire soon and is Family or General Practice within six miles of three hospitals. Present M.D. wishes to retire soon and is concerned with his patients. Financial arrangements and over-all needs negotiable. Only those seriously interested in private practice call collect 309-699-8022 or 309-699-5525 or write William Long, M.D., Creve Coeur, Ill., 60601. (2)

**DEKALB:** Northern Illinois University Health Service needs Internist; General Practitioner; and Gynecologist or practitioner with wide experience in gynecology and family planning. Reduced paper work, better hours, inquiring patients, new health care delivery systems, and University atmosphere provide interest. Illinois license required. Equal Opportunity Employer. Write L. W. Akers, M.D., Director. NIU Health Service, DeKalb 60115. (10)

**FLORA:** Population 6,000, Patient-drawing area larger. G. P., Internist, Pediatrician. Group or solo. Office space can be arranged to suit your needs. Unusually well-equipped small hospital with excellent lab and X-ray facilities and ICU. Nearby specialty consultants. Fine school system and availability of homes. For information contact: Administrator, Clay County Hospital, Flora, 62839, 618-662-2131. (10)

**GENESEO:** Family Practice; Ped., Ob-Gyn, Int. Medicine who will also do General Practice. Population 7,000 serving area 30,000 on Interstate 80, 2½ hrs. from Chicago, 25 miles from Quad-Cities metropolitan areas, over 300,000. Safe, ideal, small city living, 110 bed ultra-modern hospital, excellent schools, recreational facilities. Hospital has just completed construction of two new modern doctor's offices on hospital property which are available immediately. Guarantee monthly gross income. Clement G. McNamara, 210 W. Elk St., Geneseo, 61254. Call collect (309) 944-6431. (10)

**HARVARD:** Population 5,200, estimated trading area 20,000. Three physicians at present, previously five. Center of rapidly growing and financially sound area.

65 miles northwest of Chicago, 30 miles east of Rockford. Contact: J. M. Holcomb, Harvard Com. Hosp., Grant & McKinley Sts., Harvard, 60033. (10)

**JERSEYVILLE:** population 8000. Trade area: 19,000. County medical society very anxious for additional physicians to locate here. 9 practicing physicians at present. Jersey Community Hospital located here; 54 beds. 20 miles from Alton. Office space available. Financial assistance available. German-Irish community. 14 protestant & catholic churches. Grade & high schools including parochial. 20 miles from Southern Ill. U., Country Club with golf course. 1 hour to St. Louis. Contact: William B. Watts, Administrator—508 W. Pine St., Jerseyville, 62052. Phone: (618) 498-2133. (8)

**LEXINGTON:** Population 1700. Just 15 minutes away from Bloomington. Office facilities available. Great need for a doctor in the community. Lucrative practice waiting. All recreational facilities nearby. Contact: Michael Payne, Association of Commerce and Industry of McLean County, 210 South East Street, Bloomington, 61701, (309) 829-6344. (8)

**LIBERTYVILLE**—Thirty-Five miles northwest of Chicago. Population 12,000—serving 40,000. Group practice of Family Physicians. Affiliated with a 175 bed hospital. Corporation benefits. Salary guarantee. Beautiful country for lake sports. Contact: Dr. Mark Fields, 716 S. Milwaukee Rd., Libertyville 60048, 312-362-1390. (10)

**METROPOLIS:** Physicians wanted. Complete office facilities. Financial assistance available. Modern, well equipped hospital serving tri-county area in scenic southern Illinois. Contact: Charles Russell, Administrator, Massac Memorial Hospital, Metropolis, 62960, (618) 524-2176. (10)

**MONMOUTH:** Services area population 30,000. Opening for Family Practice and OB-GYN. Modern well-equipped hospital—141 beds. Near Highways I-74 & I-80. Daily rail to Chicago. Flight service available. Safe place to raise family. Near medical school, liberal arts college. Contact: Roger E. Gurholt, 1000 W. Harlem Ave., Monmouth, 61462. 309-734-3141. (10)

**PAXTON:** Population 5400. Service area population 20,000. Two hours from Chicago; thirty minutes from Champaign-Urbana. This area needs another MD to share two physician clinic with a general surgeon. Free rent, office help offered. Contact: Dr. M. Y. Que, or Harry Dubets, Administrator, Paxton Community-Hospital, 651 E. Pells St., Paxton 60957, 217-379-2387. (8)

**PEMBROKE TOWNSHIP:** Population 6,000. Opening in new medical facility. Seventeen miles east of Kankakee and 60 miles south of Chicago. Financial assistance available. Contact: Andrew J. Hargrett, 135 West Court Street, Kankakee 60901. AC 815-939-7304. (8)

**PITTSFIELD:** Need family practitioners and surgeons interested in locating in rural community area. Population 4100; area 18,000. Excellent opportunity

for someone wanting to practice in a rural community. Located between Jacksonville and Quincy, on Highway 54 and 36. Contact Dr. T. C. Bunting, Illini Community Hospital, Pittsfield 62363. AC 217-285-2141 or 217-285-2113. (12)

**QUINCY:** OBG, Ind. Med., Fam. Prac., Ortho., Derm., GU to join 18-man clinic. Large modern clinic, many benefits, two well-equipped hospitals. Excellent schools, cultural, recreational advantages. Good family city. Above average earnings. Write or call collect: Mr. Judson C. Green, Quincy Clinic, 1400 Maine St., Quincy, 217-222-6550. (8)

**RANSOM:** General Practice—free rent and use of modern equipment and brick building for one year. Brick building consists of doctors's, nurses, receptionist's offices, large reception room, laboratory and office and (2) treatment rooms. 80 miles southwest of Chicago, RTE 170, St. Mary's Hospital Staff, Streator Practices Reaches A 25 mile radius. Contact Mrs. Delmar Jones; Phone 815-586-4229. (8)

**ROCHELLE:** Population 10,000. General Practitioners, Internist-Cardiologist. Group or solo practice. Located 75 miles West of Chicago, near new medical school and university. \$2,000,000 addition, 1971. Ultra-modern, 70-bed hospital; new offices adjacent. Excellent schools, recreation. Visit at our expense. Contact: Robert Knapp, Rochelle Community Hospital, Rochelle 61068, 815-562-2181. (8)

**SAVANNA:** Pediatrician, Internist, or General Practitioner. Illinois community of 5,000 population on Mississippi River. 40-bed open staff hospital; exceptional recreational facilities; excellent schools and churches of all denominations. Option to practice alone or in partnership. Contact: William J. Dayton, 202 Meadowview Knoll, Savanna, 61074, 815-273-2755. (10)

**SHELBYVILLE:** Population 6,000—drawing population 22,000. New eight man medical ctr. recently opened and attached to 100 bed hospital. Object to secure a medical practice group. Central location within commuting distane of Springfield—60 miles, Decatur 35 miles & St. Louis 115 miles. Located on large lake recreational area. Contact: John Snyder, Shelby County Memorial Hospital, 1st & Cedar Sts., Shelbyville, 62565, 217-774-3961. (10)

**STREATOR:** Internist, Family Physician, Pediatrician, Surgeon, and Orthopedic Surgeon needed to join 11 physician multispecialty group in community of 20,000 with new clinic across from new hospital, excellent practicing facilities for energetic physicians, full insurane benefits, guaranteed income; teaching opportunities. Contact: C. T. Hawkins, M.D., Streator Medical Clinic, S.C., 104 Sixth St., Streator, 61364, 815-672-0511. (8)

**WHEATON:** Pediatrician(s) to join unique medical office condominium. College town 25 miles west of Chicago. Practice arrangements flexible. Rapid practice expansion assured for right individual(s). Contact: Douglas B. Mains, M.D., Mona Kea Professional Park, 393 Schmale Road, Wheaton, 312-665-9777. (7)

# Obituaries

\***Berg, Edward Paul**, Chicago, died May 5, at the age of 82. He had been a general practitioner, surgeon; he was a graduate of the Chicago Medical School in 1916. Dr. Berg also had practiced medicine for more than 50 years.

\***Baumann, Milton C.**, Springfield, died March 21 at the age of 63. He graduated from the University of Illinois in 1937. He was affiliated with the Department of Psychiatry and Neurology at the Baumann Clinic.

\***Coombs, Robert**, Chicago, died May 29 at the age of 73. He graduated from Rush Medical School in 1925. Dr. Coombs was a former instructor in surgery at the Research Educational Hospital and a lecturer in surgery at the Grant Hospital Training School for Nurses. He also was a member of the attending staff at Grant Hospital for 47 years. Dr. Coombs was the grandson of Dr. Jacob Frank, world famous Chicago surgeon of the early 1900's.

\***Davidson, Woodram W.**, Centralia, died June 4, at the age of 62. He graduated from the University of Illinois in 1948.

\***Eshbaugh, Dorothy E.**, Chicago, died June 1, at the age of 56. She graduated from the Womens Medical School of Pennsylvania in 1942. Dr. Eshbaugh was assistant director of pathology at Michael Reese Medical Center and a professor and consultant on the staff of Chicago Medical College. Previous to serving at Michael Reese Hospital, she had served on the pathology staff at Rush-Presbyterian-St. Lukes Medical Center.

\***Garcia, F. D.**, Florida, died April 29, at the age of 80. He graduate from the Chicago Medical School in 1923.

\***Gorov, Ida Ruth**, Chicago, died December 30, at the age of 80. She graduated from the Chicago Medical School in 1917. Dr. Gorov also has practiced medicine for more than 50 years.

\***Gough, J. A.**, Florida, died May 14, at the age of 79. He graduated from Rush Medical College in 1922. Dr. Gough was an Obstetrician and Gynecologist for more than 35 years. He was to have been honored May 15 by the Presbyterian-St. Lukes Hospital on the 50th anniversary of his enrollment on its staff, where he became an emeritus member of the staff 16 years ago.

\***Gurvey, Julius A.**, Chicago, died May 9, at the age of 69. He was Medical Director for the Wilson Sporting Goods Co. and Steel Supply Division of the United States Steel Corp. Dr. Gurvey also was a staff member of St. Elizabeth's Hospital. He was a 1929 graduate of the University of Illinois.

\***Hickerson, R. G. Sr.**, Galesburg, died June 5, at the age of 66. He graduated from the University of Illinois in 1933.

\***Jones, Alexander J.**, Springfield, died April 3, at the age of 73. He graduated from the University of Edinburgh, Scotland in 1928.

\***Lodato, Victor**, Chicago Heights, died May 24, at the age of 62. He graduated from the Chicago Medical School in 1941. Dr. Lodato was an associate of the Boulevard Medical S.C., in Chicago Heights. He was also a staff member of St. James Hospital for more than 30 years and also a past president of the hospital.

\***Matthies, Mabel**, Arizona, died March 26, at the age of 91. She graduated from the Dearborn Medical School in 1907. Dr. Matthies practiced medicine for more than 50 years.

\***O'Malley Sr., Francis X.**, Chicago, died June 2, at the age of 77. He had been a physician and a staff member of St. Joseph's Hospital.

\***Rudder, Ralph C.**, Arizona, died May 15, at the age of 69. He graduated from the Chicago Medical School in 1945.

\***Sass, Louis A.**, Oaklawn, died May 22, at the age of 60. He graduated from Rush Medical School in 1939. Dr. Sass was a past president of the staff at Evangelical Hospital. He was also past president of Christ Community and associate professor of medicine at Rush Medical School.

\***Van Alyea, O. E.**, Winnetka, died May 5, at the age of 87. He had been a well known otolaryngologist, best known for his international text books on nasal sinuses. Dr. Van Alyea joined the faculty of the University of Illinois College of Medicine as an assistant in otolaryngology in 1929 and became Clinical Professor of otolaryngology in 1941. When he retired in 1957, he was honored with emeritus status. He continued his interest in education and research.

\***Watt, Lucille**, Chicago, died June 3, at the age of 78. She received her Medical degree from Rush Medical College in 1943. Dr. Watt served on the staff of Billings, Presbyterian and Passavant Hospitals, where she was director of anesthesia from 1959 until she retired in 1964.

\***Wittler, Marie H.**, Arkansas, a former resident of Elmhurst, died March 25 at the age of 64. She graduated from the Washington University School of Medicine, St. Louis, Mo., in 1937.

\*Denotes member of ISMS

\*\*Denotes member of 50-Year Club of ISMS

# CLASSIFIED ADVERTISING

## Positions & Practice Opportunities

**IMMEDIATE FAMILY PRACTICE OPENING**—in two man clinic. Libertyville, Illinois, 35 miles northwest of Chicago. Initial salary and early partnership. Busy practice in small suburban town. Call collect—Dr. Lawrence C. Day (312) 362-1447.

**WANTED: OB-GYN, SURGEON and INTERNIST** for nine man group. Thirty miles southwest of Chicago, excellent hospital, housing and schools. \$30,000 guarantee first year. Write to Box Number 782, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

**ATTENTION PHYSICIANS! CHICAGO MEDICAL CENTERS**—Welfare area in need of physicians. Please contact: Mr. Robert Fields (312) 236-2555.

**GENERAL INTERNISTS and GENERALISTS:** For growing sub-sections of 45 man medical department, including allergists, psychiatrists, neurologists, all sub-specialties and expanding primary care section. Multispecialty group of 120. Large patient population and area referral. Functioning HMO. Generous salary and fringe benefits. Peaceful setting near Wisconsin vacationland and cities. Good schools, cultural advantages, Junior College. Educational and research programs. Liberal schedules, little practice pressure. New Clinic and hospital developing. Write or call J. L. Struthers, M.D., Marshfield Clinic, Marshfield, Wisconsin 54449.

**FAMILY PRACTITIONERS**—Expanding 880 bed multiple facility medical center in Chicago is seeking family practitioners (individual or groups) to join the staff of its family practice oriented facility—230 bed hospital located on the near West Side. The hospital will provide an office and furnish equipment to establish private practice at a mutually agreeable site in the nearby community—no investment by physicians required—and guarantee annual private practice income to a \$36,000 minimum for one to five years (negotiable). Send Curriculum Vitae to Box 825, c/o Illinois Medical Journal, 360 N. Michigan Avenue, Chicago, Illinois 60601.

**OZAUKEE COUNTY NEEDS Family Practitioners, Orthopedist, and Pediatricians** to provide health care for over 55,000 affluent people. St. Alphonsus Hospital, located in the center of Ozaukee County, is an orderly, modern facility ready to provide acute hospital care. Office space is available here and in nearby cities and villages. Contact George A. Seidenstricker at St. Alphonsus Hospital, 743 North Montgomery Street, Port Washington, Wisconsin 53074. Phone 414-284-5511.

P.S. Spend the day with us so we can show you and your family everything . . . schools, shops, homes, parks.

Immediate opening for **Ob-Gyn, Internal Medicine, and Orthopedic** specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

**A BETTER PLACE TO PRACTICE MEDICINE:** Enjoy practicing medicine in a warm climate, and with the friendly people in Wichita Falls, Texas. Our brand new 55,000 square foot clinic building has new offices and examining rooms ready for specialists in Internal Medicine, Family Practice, and Diagnostic Radiology. We are a multi-specialty group located in a city of 100,000 people in North Central Texas—close to everything—but away from big city problems. Call collect Dr. Preston McCall at (817) 766-3551, at 501 Midwestern Parkway, East, Wichita Falls, Texas 76302.

**ANESTHESIOLOGIST**—Immediate opening with fully-accredited modern trauma center hospital in progressive and growing community. Excellent guarantee. Contact Administration, St. Joseph's Hospital, Bloomington, Illinois 61701, (309) 662-3311.

## Positions & Practice Opportunities (Con't)

**PRACTICE and OFFICE AVAILABLE**, about August 1, 1974, in a growing central Illinois town. Size 10,000, local hospital 75 beds, and 6 area nursing homes. Principally GP, OB, Geriatrics & industrial practice. Price Negotiable. Present location 35 years. Income 50,000-75,000. Reason for moving, health and age. Write: Box 831, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, IL 60601.

**FAMILY PHYSICIANS OR GENERAL INTERNISTS - NEW MEDICAL CENTER, COUNTRYSIDE-LAGRANGE:** Area full or part time excellent arrangement regarding benefits 100,000 insurance (life), malpractice, Car credit card + practice pre-paid. Also H.M.O. Some Fee for service. Hal Halihan, Co-Administrator, Countryside Health Care Center, Inc. 6160 W. Joliet Rd., Countryside, Illinois 60525.

Well-established, prosperous North-Michigan Avenue, **Chicago Internist practice** available because of sudden death. Sub-specialties in Electrical Cardiography and Allergy. Especially able and loyal staff and equipment also available. Financial information and further detail furnished promptly to interested parties. Contact Richard W. Burke, Attorney, 3220 Prudential Plaza, Chicago, Illinois 60601, (312) 944-2400.

**MEDICAL DIRECTOR** for permanent, fulltime position with a neighborhood health center at the University of Illinois Hospital and Medical School. Academic appointment, excellent salary and fringe benefits. Opportunity for innovative medical care research in systems and manpower. Student and community education programs. Work with inner city population adjacent to the Medical Center complex. **ILLINOIS LICENSE REQUIRED**. Available now. Salary, rank open. Contact Edward A. Lichter, M.D., Prof. & Head, Dept. Prev. Med. & Commu. Hlth., P.O. Box 6998, Chicago, Ill. 60680. Phone, 312-996-7630. The University of Illinois is an Affirmative Action-Equal Opportunity Employer and encourages applications from members of minority groups and women.

**Full Time Physician for Outpatient Department of Prepaid Health Plan.** Five day 40-hr. week. No on call. Located in Central Illinois. New modern facility. Salary open. Tax shelter available. Contact administrator, Wabash Memorial Hospital Assn., 360 E. Grand, Decatur, Ill. 62525. Telephone: (217) 429-5246.

**GENERALIST** for full time position in university health service; 40-hr. week, no on-call responsibilities; excellent community of 75,000, three local hospitals. Salary negotiable with liberal fringe benefits including 30-day vacation and retirement plan. Illinois license. Write or call: Margaret M. Torrey, M.D., Illinois State University, Normal, Illinois 61761. Phone (309) 438-8655.

**WHY FIGHT PSRO's, HMO's, AND ILLINOIS PUBLIC AID?** Join us—minimal records, short hours, 5 weeks vacation, and 1 week medical meetings. Illinois University Retirement System, Health Insurance, and Life Insurance. Beginning salary \$25,000 and negotiable. Call or contact Director, Health Service, EIU, Charleston, Illinois. Phone 217-581-3013.

**INTERNIST; PRIMARY CARE PHYSICIAN; GYNECOLOGIST.** Internist to serve as Director of Clinical Medicine; must have residency. Gynecologist must have residency or be a practitioner with extensive experience in office gynecology and family planning services. All three must be interested in college students, new health care delivery systems, preventive medicine, health education, as well as clinic work. Salary dependent on qualifications; Illinois license required. Good fringe benefits, good geographical location. Health service has excellent modern facilities, well-developed x-ray and laboratory departments, etc. Equal Opportunity Employer. L. W. Akers, M.D., Director, University Health Service, Northern Illinois University, DeKalb, Illinois 60115.

# BLUE SHIELD REPORT

## FOR Illinois Physicians



### New Blue Shield Payment Vouchers Ready August 30 for FEP Members

The inaugural phase of the new payment system utilizing the 2-part Blue Shield Payment Voucher will begin on August 30 for members of the Federal Employees Program.

As the system is further implemented, it will phase-out the traditional method of Blue Shield payments to physicians with multiple checks for individual types of services, and substitute the 8½" x 11" computerized payment voucher that combines the physician's check with patient records by date of payment. Each of five sections of the voucher form—patient records and check—are perforated for detaching from the form.

Checks will cover up to four patients and include as many as five services per patient. In each patient record portion, data blocks include the patient's name, age, patient number, group number and

member ID number, case number and total amount paid for services in the upper part; and check number, payment date, type of service, service date, place of treatment, amount billed to Blue Shield, portion not covered by Blue Shield, payment amount and payment type in the lower portion of each statement.

The amount of the check to the physician is the total amount paid for each patient's covered services. When payment is made to the physician, a copy of the patient's statement portion of the voucher is sent to the subscriber as an explanation of benefits paid.

Place of treatment, type of service and payment type are coded by numbers and explanations are given on the reverse side of the voucher.

Payments under the new system will be made weekly by Blue Shield rather than daily and substantial savings are anticipated through the reduction in number of checks issued, with less handling and postage.

### Fall Workshops for Medical Assistants

The first meeting in the fall series of workshops for medical assistants scheduled by the Blue Shield Plan of Illinois Medical Service will be held September 4 at Pheasant Run Inn, St. Charles. Workshops for medical assistants in Will-Grundy counties, Lake and DuPage will follow in September and meetings for those in Cook County will be held at Plan headquarters during the month of October.

Invitational letters have been sent to physicians' offices in counties outside of Cook to the attention of the medical assistant. Letters to medical assistants in Cook County are scheduled to be mailed September 1.

All workshops in the fall schedule will be daytime meetings of morning and afternoon sessions. For those unable to attend morning meetings, the program is repeated in the afternoon. Morning workshops will be held from 9:00 AM to 11:30 AM, with registration beginning at 8:30 AM. Afternoon programs begin at 1:30 PM, following 1:00 PM registration, and end at 4:00 PM. Complimentary luncheons will not be served during the fall programs but coffee "breaks" will be held during the morning and afternoon meetings.

Workshop programs will be conducted by mem-

bers of the staff of the Professional Relations Department and include discussions on the two-part Blue Shield payment voucher on notification of membership benefits paid; changes in benefits in Blue Shield contracts; claim filing procedures; the Blue Shield Reciprocity Program and State of Illinois Group Insurance Program. To provide as much discussion time as possible, participating medical assistants will be assigned to groups of approximately 25, with a member of the Professional Relations staff serving as instructor. Special attention will be given to the newly-employed assistant.

Workshops for medical assistants in Cook County will be conducted in the auditorium of the Blue Cross and Blue Shield headquarters building at 233 North Michigan Avenue, Chicago. The schedule includes workshops every Wednesday and Thursday, beginning October 2 and ending October 31, except Wednesday, October 16. Morning and afternoon workshop hours and registration times are the same as for the meetings outside Cook County:

#### September Schedule Blue Shield Workshops

|                     |                   |             |
|---------------------|-------------------|-------------|
| Wednesday, Sept. 4  | Pheasant Run Inn  | St. Charles |
| Wednesday, Sept. 11 | Holiday Inn South | Joliet      |
| Wednesday, Sept. 18 | Sheraton-Waukegan | Waukegan    |
| Wednesday, Sept. 25 | Ramada Inn        | Hinsdale    |

## ASK BLUE SHIELD . . . ABOUT MEDICARE

# Optional Payment Method for Patients on Maintenance Dialysis; Training Payment for Self-Dialysis Patients

### Summary of New Instructions—Part I

Instructions issued recently by the Department of Health, Education and Welfare to Part B Medicare carriers advised that physicians may elect to receive payment from Medicare on a *direct monthly charge* basis as an alternative payment method for services to patients on maintenance dialysis.

Another new provision of the program allows physicians conducting patient training in self-dialysis to be reimbursed on a *flat fee basis* of \$500 (begun on and after July 1, 1974), per patient (subject to the Part B deductible and coinsurance) upon completion of the training course. If the course is not completed, payment will be made proportionate to the amount of time spent in training the patient.

Services include assessment of the patient's home environment; direction of and participation in the training process; counseling and training of family members; and the review of training progress.

### Determination of Monthly Payments

If a physician elects the monthly payment method of furnishing services to patients on maintenance dialysis, or for home dialysis, he bills Medicare monthly on the regular SSA-1490 Request for Medicare Payment form and receives his payment charge based on the following determinations and conversion factors:

The monthly payment total is based on the *calculated average prevailing charge* for internists' follow-up office visits in areas served by the carrier, based on 1973 charge data, multiplied by the *conversion factor* of 20 for maintenance dialysis patients and 14 for those on home dialysis.

### Elements of Monthly Method

(1) Payment may be made to either the physician who accepts assignment or the beneficiary when assignment is not accepted. In either case payment is subject to the usual Part B deductible and coinsurance.

(2) Physicians may elect the new method or continue to be reimbursed under the current method.

(3) A physician may change the method of reimbursement by giving the carrier written notification 60 days prior to termination of the agreement.

(4) When a physician elects the monthly method he also accepts certain other conditions contained in the coverage and billing procedure.

(5) The physician who elects the alternate method (or the beneficiary in non-assignment cases) will be reimbursed on a basis that reflects variations in charges, since the conversion factor

represents a *frequency* of services provided to maintenance dialysis patients and also includes specialized type of care provided when necessary by nephrologists. Charge screens for services are also reviewed and adjusted annually by the carrier and new methods of therapy evaluated as the program acquires experience.

(6) As a requirement of treatment in a facility, when a physician elects the monthly reimbursement method for furnishing dialysis services all physicians in the facility attending renal disease patients must agree to the payment method. A copy of the agreement must also be on file at the facility and with the carrier.

### Services Covered

(1) Services during maintenance dialysis for stabilized patients are covered, whether supervisory or direct, in uncomplicated or complicated dialysis sessions. Examples would be a routine predialysis examination or attendance during a dialysis treatment when a patient had a serious ailment such as pulmonary edema.

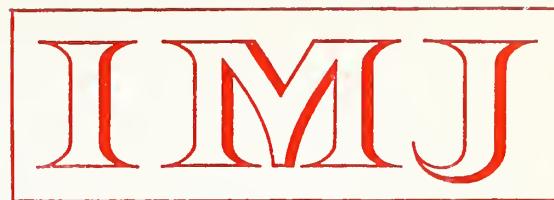
(2) Office visits are covered for routine evaluation of patient progress or for treatment of renal disease complications; also evaluation of diagnostic tests and procedures.

(3) Services rendered by the attending physician in the course of an office visit are covered. The primary purpose is routine monitoring or follow-up of complications of dialysis including prescribing therapy for illnesses unrelated to renal disease, but not exceeding the normal number of physician-patient contacts anticipated during the course of dialysis sessions or visits for treatment of renal complications.

### Summary Continued in Sept. Issue

*The new instructions on renal dialysis treatment and payment options issued to Part A intermediaries and Part B Medicare carriers are published at the request of the Department of Health, Education and Welfare. The summary of instructions in the August and September issues of Illinois Medical Journal is intended as information on the program to the general medical community. Specific details may be obtained from the appropriate service area intermediaries and carriers. (Blue Shield for Part B in Cook County).*

*Part II to be published in September issue of "Ask Blue Shield About Medicare", will conclude the summary with instructions on Dialysis Maintenance Services Not Covered; Conditions for Electing the Optional Method of Payment and the Monthly Payment Option to Patients on Self-Dialysis at Home or in a Facility.*



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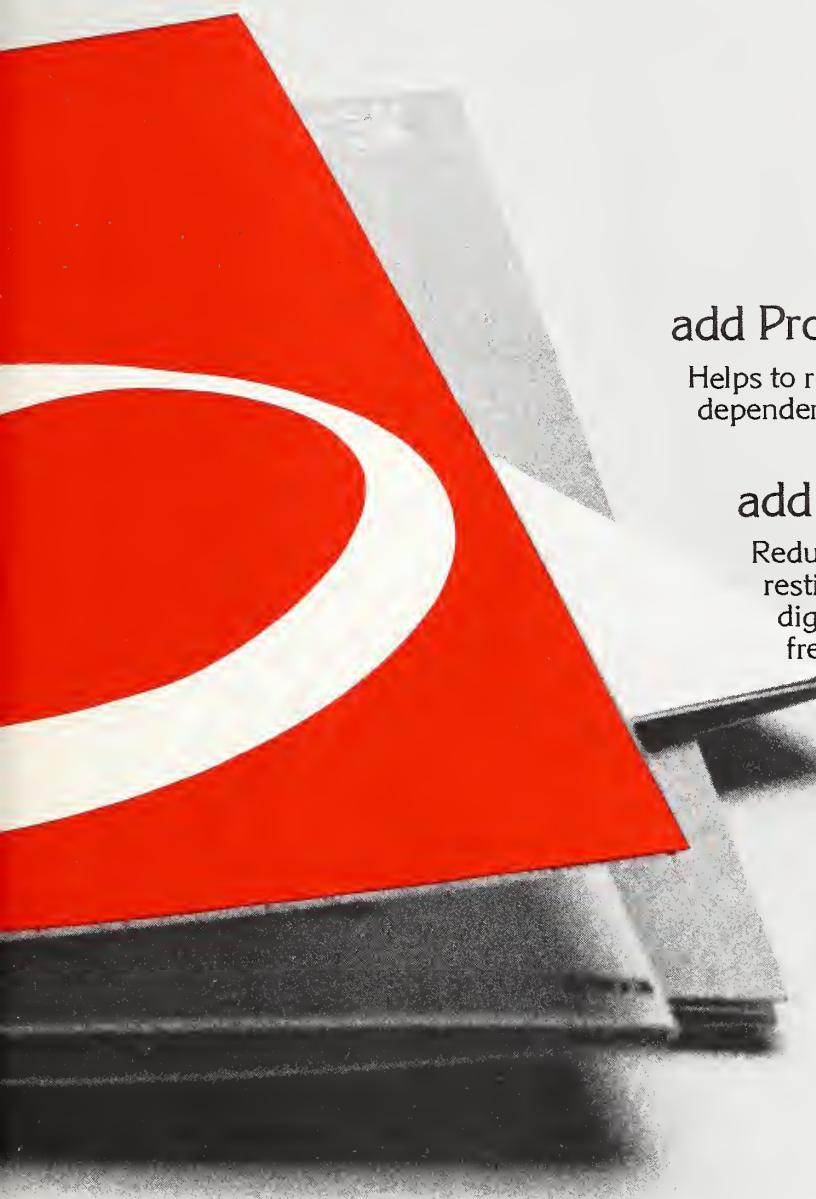
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\*Fordtran, J. S., and Collyns, J. A.: Antacid Pharmacology in Duodenal Ulcer: Effect of Antacids on Postcibal Gastric Acidity and Peptic Activity, *New England J. Med.* 274:921-927 (April 28) 1966.

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# Consider The Alternative

Despite what you read in opinion polls, doctor, not everyone loves you.

This observation reflects the gravest problem facing medicine today: **Poor public relations**.

By public relations I am not referring to the relations engineered or contrived on Madison Avenue, but to the day-to-day relationship between you, your patients and your community.

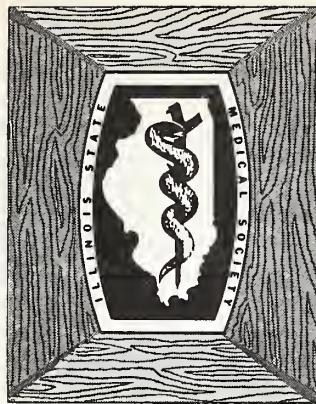
While public opinion polls indicate your patients may still worship the ground upon which you walk, many of those patients bear considerable antagonism toward your colleagues and toward the profession at large. And, your colleagues' patients hold similar views of you and the rest of the medical fraternity.

Moreover, your patients' rosy view of you is not monochromatic. While you may be respected as an astute clinician, a great diagnostician or a skilled surgeon, the image is often blurred by tinges of indifference, callousness, arrogance and greed.

Realistically, we must accept the fact that the kindly physician of yore—confidante and advisor as well as healer, always available to aid and comfort—has necessarily faded into oblivion in the wake of a scientific explosion in medicine and the parallel development of specialization. However, we cannot justify the shortcomings with which we are identified. The major complaints lodged against us are that we are not available when needed, keep our patients waiting, tolerate inefficient and inhospitable aides, are indifferent, overcharge, fail to communicate, and keep aloof from community involvement.

The frequency and volume of these charges attest to the deplorable state of our public relations—the root problem confronting our profession. A barrage of press releases and angry denials will not solve it. If it is to be resolved, each physician must recognize the validity of the public's complaints, examine his methods and attitudes, and eliminate any offending characteristics.

If you, the individual physician, fail to assume this public relations task, the private practitioner may be doomed to the fate of the Edsel.



Vol. 146, No. 2, August, 1974

## The Heroin Problem: Some Strategic Aspects

BY EDWARD C. SENAY, M.D. AND RICHARD J. WEINBERG, B.A./CHICAGO

*Heroin addiction is considered from a broad perspective. It is estimated that 0.3% of the American population is addicted to heroin. Although heroin is not pharmacologically destructive, the lifestyle of the addict is hazardous, with an estimated death rate of about 3% per year. Heroin addiction may cost the country more than ten billion dollars per year.*

*Recent experience suggests that heroin*

Heroin addiction has become a major socio-medical problem in America. Reliable statistics have never been generated, but estimates of between 350,000 and 700,000 active heroin addicts in the United States seem reasonable.<sup>1</sup> These figures imply that about 0.3% of the American population is addicted to heroin. It is clear that more and more people are becoming heroin addicts; heroin is becoming a problem in ethnic and social groups in which it has not appeared before. An example of this trend is the growing

*addiction is treatable and preventable. Treatment methods are reviewed briefly with an emphasis on the use of methadone and therapeutic communities. Prevention is discussed with emphasis on the concept of balance; that is, the elements of treatment, enforcement, education and prevention must be coordinated with a probable strategic priority on youth and in particular on polydrug using peer groups.*

number of heroin addicts in middle-class suburbs.

The death rate of heroin addicts is unknown. Heroin apparently is not a cumulatively toxic drug taken under sterile conditions,<sup>2</sup> but its illicit use is associated with risk of highly undesirable effects.

Possible causes of death associated with its use include:<sup>3,4</sup>

1. Acutely lethal doses, from unexpectedly pure street heroin, from a toxic adulterant, from synergism with other CNS or from unknown causes;
2. Embolism or thrombosis from poor hypodermic technique, or incompletely dissolved substances;
3. Hepatitis, tetanus, or other fatal infections from non-sterile needles;
4. Fatal pneumonia, tuberculosis, or other respiratory diseases not adequately treated because heroin suppresses the cough reflex;
5. Miscellaneous diseases not diagnosed in time because of the masking sense of well-being heroin gives;
6. Various diseases related to poor nutrition,



EDWARD C. SENAY, M.D., is Director, Illinois Drug Abuse Program, Chicago, and Associate Professor of Psychiatry, University of Chicago. Dr. Senay, a graduate of Yale Medical School, served internships in internal medicine and psychiatry.



RICHARD J. WEINBERG, B.A., is Administrative Assistant, Illinois Drug Abuse Program, Chicago. Previously, he served as a Counselor for the program. He is a graduate of the University of Chicago.

unsanitary living conditions, and other effects of economic hardship from the cost of heroin;

7. Murder and violent death from the criminal lifestyle associated with the high cost of heroin; and
8. Suicide related to the loss of self-esteem frequently associated with the "junkie" lifestyle.

Again there are no reliable figures, but a 3% annual death rate is an educated guess.\* This would mean that 10,000-11,000 people die each year from problems related to heroin addiction.

The social cost of heroin addiction truly is appalling. The average addict spends about \$30 a day supporting his habit, or about \$11,000 a year.<sup>5</sup> Assuming there are 400,000 active addicts, they must spend about \$4.5 billion per year on heroin. But this is only part of the cost of heroin addiction.

Few addicts can get the money they need to support their habits honestly. By and large, they get their money by stealing, prostitution, dealing drugs, forging checks, and so on. If a robber steals a television set worth \$200, he will be lucky to get \$70 for it. To make \$11,000 in a year, one must steal over \$30,000 worth of merchandise. If 25% of addicts steal merchandise to support their habit, that adds \$2 billion to the price tag.

It has been estimated that over 20% of all persons arrested for property crimes are heroin addicts.<sup>6</sup> Perhaps 30% of inmates of correctional institutions are addicts. If we charge 20% of the bill for police protection and 25% of the bill for maintaining correctional facilities to addiction, we add another \$1.5 billion to the cost. The fact that most addicts must be criminals to support their habits means that about 300,000 people are lost from the job market, costing the country some \$2 billion. These figures are approximate, but the total price tag may well be over \$10 billion.<sup>7</sup>

The true cost to society is not measurable in terms of dollars. It is estimated that 35-50% of all burglaries and thefts are heroin related.<sup>8</sup> It seems clear that a good deal of the rising crime

\*Statistics on all aspects of illegal activities are notoriously unreliable.<sup>1</sup> The 3% annual death rate mentioned in the text is based on a study at TCU.<sup>21</sup> This study evaluated the death rate of ex-addicts in treatment programs, and found that while the median age of patients was 25, the annual death rate was 1.5%. We have assumed this rate doubles for addicts not in treatment. Although common estimates are lower, these estimates are methodologically weak. Some even give higher figures.<sup>22</sup>

rate is directly attributable to this. The destructive effect of such crime is unmeasurable, but obviously substantial. In other words, heroin addiction is a major contributing factor in the high crime rate, which may be the greatest public concern today.

Current strategic thinking divides the problem into two broad areas dealing with the addict, treatment and prevention.

## Treatment<sup>9</sup>

Until recently, there was no effective treatment of heroin addiction. This has radically changed with the work of Diederich, and that of Dole and Nyswander. Diederich founded Synanon, the prototype of drug abuse therapeutic communities. These therapeutic communities, of which there are now over 100, are generally operated on a common set of principles. They are long term residential facilities, which try to substitute dependence on people for dependence on drugs. The counselors in such facilities are predominantly ex-addicts. In the process of rehabilitation the addict is required to attend group sessions—typically encounter groups; as therapy progresses, as measured by behavior and length of time in treatment, he is rewarded by being given more responsibilities in the house, greater esteem by his peers, and more privileges. These rewards may be taken away for "negative behavior" such as infractions of house rules.

The therapeutic community is quite successful with a certain percentage of addicts. People who remain in treatment have a low recidivism rate, are highly motivated to achieve, and may act as "anti-drug users," either by personal contact, or as employees of drug abuse programs. On the other hand, therapeutic communities are expensive, and relatively few patients complete treatment. Therapeutic communities are probably the treatment of choice for perhaps 10% of heroin addicts.

Dole and Nyswander developed methadone maintenance, in which an addict is given a daily dose of methadone, a synthetic opiate, as a substitute for heroin.<sup>10</sup> They found that methadone reduces the craving for heroin and blocks the effects of using heroin. A high percentage of addicts given methadone stop using heroin.

It now appears that methadone can be only part of a successful treatment modality.<sup>11</sup> To optimize success rates, a methadone maintenance clinic must provide non-chemical sources of support, such as counseling, vocational rehabilitation, job placement, legal services and medical

services. Such clinics have some success with at least one out of two patients, success being measured in terms of patient retention, reduction or elimination of illicit drug use, and reduction or elimination of illegal activity.<sup>12</sup>

The advantages of methadone maintenance are high patient acceptability, high retention rate, and low cost. The primary disadvantage is that methadone is an addictive drug, and the possibility is always present that someone who is not an addict, or who would otherwise stop taking drugs altogether, may become addicted to methadone. Methadone maintenance is the current treatment of choice for long term opiate addicts with low to moderate motivation for change.

Psychotherapy has had a fairly poor record in addict populations. Although some addicts have recovered with psychotherapy alone, it is a long, painful process with low success rate. It is prohibitively expensive for most people.

Various religious sects have reported substantial success in rehabilitating addicts, notably the Black Muslims and the Pentecostal Church. Apparently, the rehabilitative process within these sects is similar to that of therapeutic communities—they provide a powerful emotional substitute for drugs. Although the overall rehabilitation rate is rather low, it may be the treatment of choice for certain motivated addicts with strong religious background.

Dr. Jerome Jaffe pioneered the "multi-modality" approach to drug rehabilitation.<sup>13</sup> An unfortunate tendency of exclusionism exists in many treatment programs—"Our is the one true way." In Illinois we have found that modalities need not be mutually exclusive. It appears that best treatment results come when addicts are offered a variety of different rehabilitative options.

## Prevention

Much of the work in preventing heroin addiction is not immediately recognizable as such. Paramount in this category are the set of laws regulating narcotics and the efforts of police and customs authorities to stop the flow of opiates and to imprison so-called "pushers." Obviously, restricting availability of narcotics through the laws concerning legal dispensation of opiates has done some good. At the turn of the century, large segments of the population, especially middle-aged housewives, used various patent medicines containing opiates.<sup>14</sup> Although the people who became addicted this way often continued to use opiates despite legal sanctions, the modern mid-

dle-aged housewife is very seldom an opiate addict.

Police and customs work has failed to eliminate heroin from America, and there is considerable evidence that it cannot.<sup>15</sup> However, by making heroin more expensive and less accessible than it might otherwise have been, this effort has probably prevented many people from becoming addicts. Much of the frustration attached to police narcotics work is due to the desire to deter addicts from using drugs. If we could perceive this work as designed to reduce the incidence of new addiction, rather than to eliminate established addictive behavior, we could be more optimistic about the situation. In light of this, more emphasis should be placed on controlling heroin distribution, and less on arresting or harassing the confirmed addict; but probably police work is about as effective as it can be. We should note in passing that about 50% of those ordinarily described as addicts at least occasionally "push" drugs.<sup>16</sup> But as is the case with all other attempts to ameliorate the drug problem, the enforcement effort suffers from its failure to be part of a coordinated strategy.

We have recently seen a good deal of effort put into drug education, school programs, TV commercials, posters, and so on. The hypothesis is that education about the dangers of drug abuse will reduce the incidence of new cases. Although this hypothesis may be true, results to date have been disappointing. Much of the work has been poorly designed, poorly thought out, and completely unevaluated. While drug education may be worthwhile in itself, education as prevention needs a good deal more careful study before full-scale implementation should be considered.

The context in which education occurs probably is as important as the content of the educational attempt. Education might have a powerful effect if it occurred as an element in an overall drug strategy, but to date we do not know what could be achieved because of the fragmentary nature of our strategic thinking; current education efforts have not been coordinated with other elements in the attack on the problem.

There are identifiable conditions conducive to addiction, and while many of these are quite difficult problems indeed, it is worthwhile at least to consider them. The American culture has become drug oriented. We are urged to take a pill to solve problems ranging from insomnia, to anxiety, to depression and fatigue, to difficulties with in-laws. There may be a tendency among doctors to over-prescribe medication for minor

ailments. Medicine has become a panacea and ritual object. We see some effort to change this tendency—more responsible advertising, greater caution by doctors in prescribing, and so on, but we have a long way to go in this area. Anti-drug propaganda could and should be a component in a balanced and comprehensive attack on the drug problem.

Also, we note that such things as vehicles, communications, ideas, values, people, move faster now than ever. The sensory input a person must deal with in a day has grown at an enormous rate. Along with this is a certain lack of stability. Our deepest values are questioned. The family unit is weakening, with no substitute source of emotional stability available. These facts of modern life possibly create more anxiety, anomie, and tension, and may lead to more ulcers, heart attacks, suicides, and drug addicts. We do not pretend to offer a solution to these problems, but a reasoned approach to even these complex problems is conceivable and should be a part of the overall attack on drugs.

We also know that poverty, racism, unemployment and other social problems endemic in our central cities are associated with drug addiction. These problems are theoretically solvable, and we need to include consideration of them in any strategy on drugs. Methadone alone, for example, is a short term solution in some ghettos and barrios, but we had better present a package of methadone plus jobs and educational opportunities if we want real progress in the war on drugs.

### The Use of Heroin

We have learned a great deal in the past five years; such as knowing that addicts are almost never introduced to heroin by the mythical school yard dope peddler. People are offered heroin by their friends and peers.<sup>17</sup> Heroin use typically starts out as an adolescent dare. Epidemiological studies suggest that heroin spreads within groups—either friendship groups, in the case of micro-epidemics, or whole communities, in the case of macro-epidemics.<sup>18</sup> Within the group, the heroin addict is a respected member who enjoys high status. Apparently heroin spread requires both a supply of active users and a subculture in which drug use is perceived as desirable.

It is apparent that heroin use is correlated to the prior use of other illegal drugs. What has not

been fully explained is the nature of this relationship. The naive conclusion that the use of marijuana, amphetamines, barbiturates, and other drugs causes a person to use heroin is a gross oversimplification. The use of these non-opiate drugs defines a subculture—the “polydrug” subculture. It is much more likely for a person to be introduced to heroin if he is already in the polydrug subculture than if he has never used drugs. This in no way means that polydrug use causes heroin use but rather that many heroin addicts are recruited from the polydrug subculture.<sup>19</sup>

The existence of heroin in America despite all the best efforts of the police, customs, and federal narcotics agents to the contrary, is eloquent testimony to the intense craving of the addict, the enormous profits in the heroin black market, the power and ingenuity of heroin smugglers, and the relative ease of smuggling a few tons of contraband into the country each year. The single most effective way to close a black market may be to eliminate consumer demand; that is, to rehabilitate addicts.

Some of the points in the preceding paragraphs became clear to us in the course of our work with heroin epidemics.<sup>20</sup> In 1970 a sizable heroin outbreak was identified in a relatively isolated Chicago community of 15,000. Preliminary investigation revealed about 100 heroin addicts in this community, almost all of whom had become addicted after 1966. In 1971 we opened an intensive community-based rehabilitation program. Most of the addicts came into treatment and most of the remainder moved out of the community. Heroin has been relatively unavailable within the community since January, 1972. On the basis of this experience, it is suggested that if a metropolitan area made an all-out effort to implement well-structured drug programs that were accessible to the entire population, not only would few addicts remain, but few new addicts would appear. In other words, we should try making massive strikes on defined areas rather than continuing to dribble our limited resources over too many areas.

### Summary

To summarize some of the important lessons which should determine the drug strategy for the 70's:

- There is no reason for apathy. We don't know all we might about rehabilitation. There is still a need for research. But we

do know enough to take decisive action against heroin, provided we have the will.

- Heroin addiction is spread by friends, not pushers. In the drug subculture, heroin is considered "good," not "bad," and as such is something offered to friends, not strangers. Most "pushers" will not sell to a stranger, who might be a policeman.
- If treatment is available, convenient, and offered in an acceptable form, many addicts use it. In a pilot project, about 80% of addicts in a community voluntarily sought treatment when a treatment center opened in their community.
- To be successful, a treatment program must include representatives from the community it wants to serve, both in planning and implementation.
- Community and neighborhood groups must play an active role in focusing the community's attention on drug abuse and defining the community's relationship to the treatment center.
- Jobs, adequate housing, and similar basic needs must be available to those addicts who seek rehabilitation. An addict's drug prob-

lem is only part of a constellation of problems making him feel helpless and hopeless.

- Any drug program must be accountable to recognized principles of professional practice, and to the community in which it operates.

Finally, we need an explicit, comprehensive, balanced strategy on federal, state, and local levels. The strategy should attack different aspects of the problem in a coordinated sequence. It almost certainly should aim its main force at the polydrug-using youth subculture as the main target for prevention, since this group represents the largest pool of illicit drug users.

We have the resources and the know-how to reduce greatly the severity of the problem of chemical dependence in our society. Somehow we need to synthesize the knowledge and skills available in order to become even more aggressive about what was once thought to be an unsolvable problem. ▶

#### References

A complete bibliography for "The Heroin Problem: Some Strategic Aspects" may be obtained by writing to the *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago, 60601.

## Conference Workshop On DRUG and ALCOHOL DEPENDENCIES

**October 4, 1974**  
**Ramada Inn,**  
**Bloomington, Ill.**

Physicians, school nurses, school counselors, school administrators, allied health personnel, emergency department personnel, pharmacists, enforcement (youth) officers, community workers and interested persons are invited to attend one or both days of the workshop.

**October 5, 1974**  
**Union, Illinois State University,**  
**Normal, Ill.**

Subjects to be discussed include:  
**The Abusive Substances Problem in the Schools**  
**The View of Enforcement Officials**  
**Teaching About Dependencies**  
**What To Do Until The "Doctor Arrives"**  
**Drugs and the Law**  
**What is Dependency?**

Advance registration will be accepted until September 27, 1974. For information, write or phone, Illinois State Medical Society, Division of Scientific Services, 360 N. Michigan Ave., Chicago 60601; 312-782-1654.

# Alcoholism—A General Hospital Meets The Challenge

BY JAMES W. WEST, M.D./EVERGREEN PARK

The program at Little Company of Mary Hospital, Evergreen Park, for the care of alcoholism patients can serve as a model for any general hospital. The prevalence of alcoholism accounts for about 30% of all general hospital admissions. Although the primary diagnosis for these patients may not be specified as "alcoholism," the reason for hospitalization is usually related to alcohol use.

There are three important factors which have emerged in our society to hasten our directly addressing the responsibility for the care of the alcoholism patient. These factors include, firstly, "Legal Power" which has resulted in the Uniform Practice Act removing the inebriate from the criminal justice system making him a responsibility of the health care system. In addition, there have been successful malpractice litigations for refusal to treat the alcoholic patient.

Secondly, there is "Green Power," money, provided by health insurance carriers, who, by law, must cover the treatment of alcoholism as new insurance contracts are written. In addition, Federal legislation provides \$375 million in the next two years for both alcoholism care and the training of health care professionals.

Thirdly, there is "People Power," a new attitude by the public about this sickness. Educational information has helped people recognize alcoholism as an illness for which they expect the best possible treatment as they do with any other sickness.

At Little Company of Mary Hospital, a plan was put into operation which provides care for the acutely ill alcoholism patient and initiates his long term recovery through a system of in-patient services and effective after-care referral relationships. This program functions with the support and participation of Administration,

JAMES W. WEST, M.D., serves on the Illinois State Medical Society Committee on Alcoholism and Drug Dependence. He is affiliated with the Department of Psychiatry, Rush-Presbyterian-St. Luke's Hospital, Chicago; Assistant Professor, Department of Psychiatry, Rush Medical College; and Assistant Director, Department of Surgery, Little Company of Mary Hospital, Evergreen Park.

*Editor's Note: See Guest Editorial, page 131 on Model Cities—CCUO's Alcoholism Recovery and Rehabilitation Program.*

Medical Staff, Nursing Services and the Department of Patient and Family Counseling.

The start of the program at Little Company of Mary Hospital was preceded by a period of inservice training, participated in by emergency care personnel and members of the Nursing Services Department. The training program included lectures and discussions about the nature of the disease and a review of its spectrum of treatment. Attitudes of the treatment personnel were particularly stressed. Bedside teaching of nurses, residents and interns and frequent review of each patient's responses to treatment is an intrinsic part of the program.

Patients are admitted to the hospital with the diagnosis of "alcoholism—acute withdrawal syndrome." The patients are placed on the medical service and their treatment is reviewed, as with other illnesses, by the Department of Internal Medicine.

The treatment program in this hospital is an organized multidisciplinary diagnostic and therapeutic system. The admitting physician retains the primary responsibility for the care of the alcoholism patient, but shares the treatment effort with a team of professionals who participate in the various aspects of the recovery procedure process. The sophisticated medical back-up systems are entirely adequate to properly serve the acutely ill alcoholism patient in the community. A long-term alcoholism rehabilitation unit, or an isolated unit for the care of the short-term alcoholic, is not necessary. The hospital can meet its community needs without the addition of any medical beds by treating acute alcoholism patients in the regular medical beds without isolating them from other medical patients. Adequate medical management makes this system of patient distribution practical. Empathetic and informed nursing care along with adequate medication have proven this system to be feasible by a large experience.

The actual system of care begins with the emergency room procedures. Transportation of the patient is usually by police vehicle or private auto. Upon arrival, immediate care of the patient is begun with the triage process wherein the diagnosis is made, the urgency of the patient's

condition is determined and the type of care is assigned.

At Little Company of Mary Hospital, urgency of care is determined by assessing which stage of acute withdrawal from alcohol exists. A person who is merely intoxicated, but not suffering from withdrawal symptoms, is usually not in need of hospital admission unless there is some additional pathologic process which might be aggravated seriously by the alcohol.

The phases of withdrawal from alcohol are the conditions which are potentially health or even life threatening. These conditions invariably follow prolonged ingestion of large amounts of alcohol. The emergency department uses the following staging system in processing the acute alcoholism patient:

*Stage I* consists of psychomotor agitation (the "shakes"), autonomic hyperactivity (tachycardia, hypertension, hyperhidrosis and anorexia.)

*Stage II* consists of hallucinations—these are auditory, visual or tactile; there may be one or a combination of these. The hallucinatory experience is usually frightening and there is usually an amnesia for details of this experience. However, the patient is oriented as to time, place and person.

*Stage III* consists of delusions, disorientation, delirium, plus all of the above, with severe psychomotor agitation. This may be intermitent, but is always followed by amnesia.

*Stage IV* consists of convulsive seizure activity.

The management of the patient is determined by the stage of the acute withdrawal syndrome that exists. Usually, the Stage I withdrawal patient may be discharged with a mild medication and be followed in an out-patient treatment setting. The usual medication used for this situation is hydroxyzine (Vistaril®), in modest amounts, and a one day supply to be renewed by the physician at the outpatient clinic when the patient returns the next day. This stage may be unpredictably progressive so, if a patient gives a history of having previously experienced seizures during withdrawal, he is admitted for a 24 to 48 hour period. Seizures show a 70% recurrence rate with each withdrawal experience.

Since hallucinatory activity of Stage II frequently proceeds to the next and much more serious Stage III, these Stage II patients are admitted to the hospital. Both Stage II and Stage III are treated with adequate sedation to control the psychomotor agitation and a neuroleptic agent (chlorpromazine [Thorazine®], or halo-periodol [Haldol®]) to manage the hallucinatory

phenomena. The Stage III patient is usually very ill. This state has been traditionally described as the D.T.'s. Stage III is rarely due to alcohol alone; trauma, infection, multiple drug use, hypovolemia or electrolyte imbalance are usually also present.

Stage IV acute withdrawal states are characterized by seizures which are controlled by diazepam (Valium®), or some other anticonvulsant agent. Sodium diphenylhydantoin (Dilantin Sodium) is not effective for about 72 hours.

This method of emergency room staging has made the processing of the acutely ill alcoholic a more effective procedure. All of the physicians and the nurses in the Emergency Department are familiar with the diagnostic criteria of this system. Appropriate treatment starts in the Emergency Room consistent with the exact nature and urgency of the condition.

Those Stage II, III, and IV patients, all of whom are admitted to the hospital, are given medication while still in the emergency room. When the patient exhibits an intense psychomotor state, he is usually held in the emergency area until he responds to the medication.

All persons who are admitted do so voluntarily. When there is an acute bed shortage, Stage I and Stage II patients are referred to other hospitals where arrangements have been made to accept these referrals.

Admission procedures include using the diagnosis of "acute alcoholism—withdrawal syndrome." The patients are admitted to the medical areas where they are placed with the other medical patients. The additional use of medication has effectively eliminated the use of physical restraints, except in the rare and short term use of a waist Posey belt in the Stage III patient. A set of standing orders, which have been the focus of inservice training, gives the nursing personnel the use of sedation as they see the need for the patient. Although there are many effective drugs for use in the withdrawal syndrome, one drug has been chosen so that all those who administer it can become familiar with its effectiveness and its limitations. This drug chlordiazepoxide (Librium®) has had wide use and its limitations and safety features are well known. After the patient has recovered from the acute withdrawal syndrome, he is taken off all sedation. Occasionally he may continue the use of a neuroleptic or an anticonvulsant drug if this is indicated. If a patient suffers from concomitant physical disorders, they are treated simultaneously with the withdrawal therapy.

Three considerations in the treatment of the acute withdrawal syndrome should be mentioned. These are, effects of withdrawal on 1) central nervous system, 2) fluid and electrolyte balance, and 3) abnormal glucose metabolism.

The central nervous system demands immediate attention in the form of adequate sedation to combat the psychomotor activity. This condition is probably due in part to an increase in intracellular sodium and a decrease in intracellular potassium brought about by alcohol and its effect on mitochondria produced ATPase. This enzyme, a necessary part of the active transport system within the cell membrane, keeps the sodium and potassium ratio in a correct state. An abnormal ratio reduces transcellular membrane potentials thus increasing excitability of nerve and muscle tissue. Sedation controls this condition of tissue excitability, and abstinence from alcohol usually restores transcellular electrical gradients within a day or two of treatment. Dilantin Sodium is given to those patients who have seizures or who have a history of seizures. This is given with phenobarbital for the first 72 hours, after which Dilantin Sodium can be given alone. Dilantin Sodium affects cell membrane physiology by decreasing intracellular sodium and increasing intracellular potassium, thus effectively counteracting one of the most prominent causes of psychomotor hyperactivity in alcohol withdrawal.

Fluid balance, contrary to traditional beliefs, is in a state of overhydration. Only when the blood alcohol level is rising is the antidiuretic hormone of the posterior pituitary suppressed producing a diuresis, mostly a free water clearance with some magnesium loss. The other electrolytes, sodium, potassium and chloride, are retained. There is retention of water and electrolytes after the blood alcohol level reaches a plateau, which is usually early in a drinking episode. Thus, when the patient is admitted to the hospital, he is in positive water balance and, because he has also retained his electrolytes, he is in a state of iso-osmotic overhydration. Unless the patient has been vomiting, or has had a diarrhea, intravenous fluids are contraindicated. The patient can usually tolerate orally whatever fluids he needs. Diuresis occurs shortly after withdrawal from alcohol has started, which restores fluid and electrolyte balance to normal levels. Magnesium levels may be low, but replacement by I.M. solution has not been done on this program since its value is controversial.

Abnormal carbohydrate metabolism is asso-

ciated with labile blood glucose levels. Alcohol depletes hepatic glycogen stores, impairs gluconeogenesis, and produces an occasional hypoglycemia of such a low level as to produce seizure activity. Blood sugar levels are followed carefully for the first four days.

Other conditions which demand careful watching are infections, possible trauma, or other physical conditions which, in common with the acute withdrawal state, can precipitate a sudden Stage III condition with delusion, delirium, hallucination and other signs recognized traditionally as the D.T.s. There are some warning signals for this stage of withdrawal which the alert physician or nurse can recognize and treat promptly.

Standing orders, which are meant to serve as a grade and base line procedure, have been reviewed with all the personnel who will deal with the patient. These standing orders have served a large number of patients and they are designed to be modified to meet the individual needs of each patient.

The following is the order sheet for patients admitted for acute alcoholism:

#### ADMITTING DIAGNOSIS:

Acute Alcoholism  
Acute Withdrawal Syndrome—Alcohol  
Other Medical or traumatic conditions if present

| ADMISSION ORDERS: | LABORATORIES:                         |
|-------------------|---------------------------------------|
| STAT              | DRAW IN AM,<br>FOLLOWING DAY          |
| CBC               | SMA 12/60                             |
| Urinalysis        | S.I.C.D.                              |
| Blood Drug Screen | S.G.P.T.                              |
| Glucose           | Triglycerides                         |
| Blood Alcohol     | Coagulation Survey                    |
| Chest X-ray       | ECG                                   |
| Electrolytes      | Bland or General Diet as<br>tolerated |

#### MEDICATIONS AND NURSING:

##### Start in Emergency Department

1. Inj. Librium® 50 mg. IM. STAT; and 50 mg. of Librium® may be repeated every one/half hour if patient is very restless.
2. Inj. Librium® 50 mg. IM. every 3 to 4 hours; but do not awaken patient if asleep.  
(This dosage to be changed as indicated)
3. Inj. Sodium Amytal® gr. iii IM. at about 10:00 p.m. for sleep if necessary.
4. Inj. Thiamine Hydrochloride® 200 mg. IM. b.i.d.
5. Take Berminal "500"® (i) b.i.d.
6. Have relative remain with the patient after patient reaches the floor until nurse indicates this is no longer needed.
7. Do not use restraints.
8. Notify physician about admission and patient's condition and call physician's resident or intern.
9. Observe patient closely for any rise in temperature, or profuse perspiration, or hallucinations, as these signs may indicate impending Stage III Withdrawal. Notify physician or his resident.

10. Daily therapy sessions at 1:45 p.m. in North Pavilion, Room 226, Patient and Family Counseling Department.
11. A.A. Meetings on MONDAY, WEDNESDAY, FRIDAY EVENINGS. 8:00 p.m. (MONDAY AND FRIDAY in Meeting Room "B"—Wednesday in Board Room)
12. Further workup as indicated.
13. Notify Alcoholism Program Coordinator of patient's admission.

Psychosocial therapy begins on admission of the patient to the emergency care system. This starts with the same caring and accepting attitude as the nurse or physician would have with any other kind of illness. The patient is assured of help and relief by personnel who understand that their approach is effective in allaying fears and damping psychomotor agitation. 95% of alcoholism patients enter psychosocial treatment by way of some physical or acute social crisis. Their initial contact with the helping professional may set the direction of their eventual recovery process.

At Little Company of Mary Hospital the psychosocial therapy begins on admission and continues throughout the patient's stay. The physician counsels daily with the patient, outlining the physical effects of alcohol use and helping to plan goals for rehabilitation. An alcoholism program coordinator sees each patient soon after admission and daily thereafter, explaining the alcoholism program, providing literature and discussing the Alcoholics Anonymous and Alanon programs. The patient's family is involved in the program by introduction to Alanon groups.

### **Group Therapy**

Group therapy has been found to be the most effective alcoholism treatment modality and the patient is introduced to this as soon as he is physically able to attend. Some patients are brought by wheel chair to the daily sessions. This therapy consists of didactic sessions given by a physician covering the physical effects of alcohol use. Group psychotherapy, conducted by trained alcoholism therapists, uses the orthodox psychotherapeutic techniques including transactional analysis, group process, communication and some psychodrama. Alcoholics Anonymous meetings take place on three evenings a week at the hospital and are participated in by the patients and community members of A.A. Film presentations on alcoholism for staff and patients are shown and discussed. These films are produced by the American Hospital Association and are provided by the South Suburban Council on Alcoholism as a service to the community. A workshop group

takes place on Saturday for patients and ex-patients. The goal of this session is insight development, particularly as it pertains to alcoholism in the patient's life and family. Alanon groups for spouses of patients meet on the hospital campus once a week.

Psychometric testing is done on those patients designated as needing this by the physician. These include the Bender-Gestalt, the Shipley-Raven Matrix and the M.M.P.I. tests. Psychiatric consultation is available and used on very depressed and otherwise psychiatrically disturbed patients. Some psychiatrists have referred their alcoholism patients to the alcoholism program in the medical section. They thus conserve the psychiatric beds for their patients who require confined care.

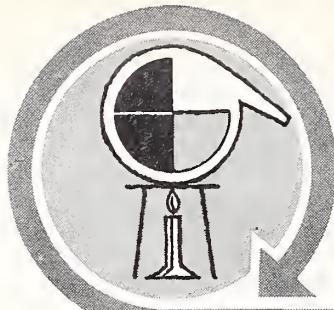
After-care is an essential component of any acceptable alcoholism program. This consists of directing and following, or referring, the patient for continuing alcoholism therapy, the intensity of which is dependent on the individual need.

At Little Company of Mary Hospital, the acute care program is necessarily of short duration. As soon as the patient is no longer in need of physical treatment, he is directed into the after-care system. While in the hospital, he is introduced to the psychosocial system of therapy in which he will hopefully participate for the rest of his life. This kind of treatment addresses itself to the disease, alcoholism.

The process of after-care begins with the patient calling the local A.A. office on the day before discharge. This assures that members of A.A. in the patient's community will contact the patient and bring him to the local A.A. group meetings after he is discharged from the hospital. Arrangements are also made for outpatient counseling with the professional people who run the hospital group therapy sessions. The Department of Patient and Family Counseling provides family and patient counseling to those who need this service. During the hospital stay, the social worker for the alcoholism program works with the patient to solve those problems that the individual may present as part of his total alcoholic career. Some of these patients brought in by police are in need of post-hospital living accommodations or nursing home care.

There are some patients who are in need of longer inpatient care in the form of rehabilitation. These patients are transferred to one of the excellent rehabilitation centers in the city for a continuation of the psychosocial therapy to

*(Continued on page 136)*



# new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

**Single Chemicals**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

## The following new drugs have been marketed:

### SINGLE CHEMICALS

|                      |  |    |
|----------------------|--|----|
| <b>BRICANYL</b>      | Bronchodilator   | Rx |
| Manufacturer:        | Astra Pharmaceutical Products, Inc., Worcester, Mass.  |    |
| Nonproprietary Name: | Terbutaline Sulfate  |    |
| Indications:         | Bronchial asthma and reversible bronchospasm occurring with bronchitis and emphysema.                |    |
| Contraindications:   | Known hypersensitivity to sympathomimetic amines.  |    |
| Dosage:              | 0.25 mg. subcutaneously into the lateral deltoid area; additional doses according to package insert. |    |
| Supplied:            | Ampules, 2cc, cc/1 mg.   |    |
| <b>CEFADYLY</b>      | Broad Spectrum Antibiotic  | Rx |
| Manufacturer:        | Bristol Laboratories   |    |
| Nonproprietary Name: | Cephapirin Sodium  |    |
| Indications:         | Infections caused by susceptible organisms.  |    |
| Contraindications:   | Known allergy to cephalosporins  |    |
| Dosage:              | See package insert   |    |
| Supplied:            | Vials, 1 Gm., for i.m. or i.v. inj.  |    |
| <b>MONISTAT</b>      | Topical Fungicide  | Rx |
| Manufacturer:        | Ortho Pharmac. Corp.   |    |
| Nonproprietary Name: | Miconazole nitrate   |    |
| Indications:         | Local treatment of vulvovaginal candidiasis (moniliasis)   |    |
| Contraindications:   | Hypersensitivity   |    |
| Dosage:              | One applicatorful once daily at bedtime  |    |
| Supplied:            | Water miscible cream, 2%   |    |

### DUPLICATE SINGLE DRUGS

|                      |                              |    |
|----------------------|------------------------------|----|
| <b>LUF-IS0</b>       | Bronchodilator               | Rx |
| Manufacturer:        | Mallinckrodt Pharmaceuticals |    |
| Nonproprietary Name: | Isoproterenol sulfate        |    |

|                    |  |  |
|--------------------|--|--|
| Indications:       | Bronchospasms associated with tachycardia          |  |
| Contraindications: | Acute—1 to 2 inhalations                           |  |
| Dosage:            | Maintenance—1 to 2 inhalations 4 to 6 times daily. |  |
| Supplied:          | Aerosol, measured dose supplies 0.075 mg.          |  |

### COMBINATION PRODUCTS

|                         |   |    |
|-------------------------|---|----|
| <b>DIBAN</b>            | Antidiarrheal   | Rx |
| Manufacturer:           | A. H. Robins Company  |    |
| Composition:            | Powdered opium 12 mg.<br>Atropine sulfate 0.24 mg.                                  |    |
| Indications:            | Symptomatic control of acute and nonspecific diarrhea.                              |    |
| Contraindications:      | Pyloric obstruction, glaucoma, and urinary tract obstruction.                       |    |
| Dosage:                 | 2 tablets initially followed by 1 or 2 tablets every three to four hours as needed. |    |
| Supplied:               | Tablets   |    |
| <b>TROJACILLIN-PLUS</b> | Penicillin Combination  | Rx |
| Manufacturer:           | Holland-Rantos Co., Inc.  |    |
| Composition:            | Ampicillin 3.5 Gm.<br>Probencid 1.0 Gm.   |    |
| Indications:            | Uncomplicated infections of N. gonorrhoea   |    |
| Contraindications:      | Susceptibility to penicillins   |    |
| Dosage:                 | Single dose of both drugs   |    |
| Supplied:               | Unit dose bottle  |    |
| <b>VISTRAX</b>          | Antispasmodic Combination   | Rx |
| Manufacturer:           | Pfizer Laboratories   |    |
| Composition:            | Oxyphencyclamine Hydroxyzine HCl  |    |
| Indications:            | Adjunctive therapy in peptic ulcer  |    |
| Contraindications:      | Glaucoma, obstructive uropathy and obstructions of the g.i. tract                   |    |
| Dosage:                 | One tablet b.i.d. or t.i.d.   |    |
| Supplied:               | Tablets   |    |

### NEW DOSAGE FORMS

|                                  |   |    |
|----------------------------------|---|----|
| <b>SINEQUAN ORAL CONCENTRATE</b> | Tranquilizer and Psychostimulant                              | Rx |
| Manufacturer:                    | Pfizer Laboratories   |    |
| Nonproprietary Name:             | Doxepin HCl   |    |
| Indications:                     | Mixed symptoms of anxiety and depression                      |    |
| Contraindications:               | Glaucoma, urinary retention and hypersensitivity to the drug. |    |
| Supplied:                        | Bottles, 120 mg., cc/10 mg.                                   | ◀  |

# Sensitivity Tests on Individual Human Cancers to Pick Active Drug Therapy

BY FRANCES E. KNOCK, Ph.D., M.D., RAYMOND M. GALT, M.D., Y. T. OESTER, M.D.  
AND ROBERT SYLVESTER, B.S./CHICAGO

*Sensitivity tests on human cancers can rule out inactive drugs for clinical treatment with 100% accuracy. In our laboratories and in studies throughout the world, correlations between predictions from sensitivity tests and drug activity in clinical therapy have usually varied between 61–98%.*

Sensitivity tests on individual human tumors to select active drugs for clinical therapy have been regarded as a forward step because of their scientific advance<sup>1</sup> and accord with ethical codes and humanitarian values.<sup>1,2</sup>

Many drugs are now available for treatment of disseminated cancer. Many are extremely toxic to the patient. Use of toxic drugs inactive against an individual patient's cancer may not only deny him the benefits of active therapy but also accelerate growth of his cancer.<sup>3,4</sup>

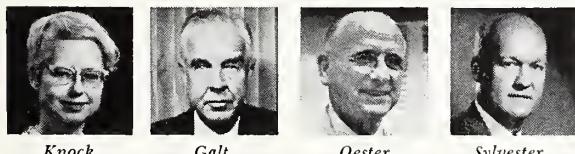
Routinely, therefore, we have come to use three sensitivity tests to rule out inactive drugs for each patient and to select one or more drugs with a good chance to be active against the

patient's own tumor. Agar plate assays; radioactive tracer studies (monitoring drug effects on tracer incorporation to DNA, RNA and protein); and the Kondo test, as modified in our laboratories, have agreed with each other in over 85% of cases.<sup>5,6</sup>

In our laboratories and in studies throughout the world, all three tests can rule out inactive drugs with 100% accuracy.<sup>4-7</sup> From studies at four university hospitals in Japan, correlations between sensitivity test results and clinical results were reported as 61–89%.<sup>4</sup> The group obtaining the poorest correlation of 61% were willing to study randomized patients treated with perfused drugs. At 9 and 18 months, survival rates were twice as great for patients receiving drugs in accord with sensitivity tests on their own tumors as for unselected patients.

Transformation of normal cells by cancer-producing viruses now appears to require an altered DNA to transcribe altered information. An altered enzyme, DNA polymerase, may be at the heart of the process. Several groups of workers have noted the promise for rational cancer drug therapy of new drugs that depress RNA-dependent DNA polymerase activity from cancer producing viruses and human acute leukemia cells.<sup>6,8</sup>

The crucial test of the significance of sensitivity tests on human cancers, as a result, may be the ability of the tests to find drugs that depress selectively the DNA polymerase activity of human cancer cells and tumor viruses. The



FRANCES E. KNOCK, Ph.D., M.D., is on the surgical staff of Augustana and VA Hospitals, Hines; Clinical Assistant Professor of Surgery at the University of Illinois and Lecturer in Pharmacology at Loyola University. Dr. Knock is listed in *World Who's Who in Science* as surgeon-chemist. RAYMOND M. GALT, M.D., is an the attending medical staff at Augustana, Cook County and Presbyterian-St. Luke's Hospitals, and Clinical Assistant Professor of Medicine at the University of Illinois, Chicago. Y. THOMAS OESTER, M.D., is Professor of Pharmacology at Loyola University, Stritch School of Medicine and on the staff of the Drug Control Center, VA Hospital, Hines. ROBERT SYLVESTER, B.S., is a chemist, Cancer Chemotherapy Research Department, Drug Research at the VA Hospital, Hines, and Director of an independent research and development laboratory.

**Table 1. Effects of Drugs on In Vitro Metabolism of Normal and Cancer Cells**

|   |      | Oxo<br>0.4<br>mg/ml | IAC<br>0.4<br>mg/ml | 5-FU<br>0.5<br>mg/ml | Meth<br>0.05<br>mg/ml | HN-2<br>0.025<br>mg/ml | Premarin<br>0.75<br>mg/ml |
|---|------|---------------------|---------------------|----------------------|-----------------------|------------------------|---------------------------|
| 1. Normal human leukocytes                | DNA  | 67                  | 60                  | 40                   | 31                    | 34                     | 90                        |
|   | SDI  | 26                  | 32                  | 65                   | 68                    | 56                     | 12                        |
| 2. Breast cancer, domestic cat (14 years) | DNA  | 52                  | 56                  | 86                   | 91                    | 56                     | 44                        |
|   | SDI  | 46                  | 43                  | 17                   | 12                    | 44                     | 56                        |
| 3. Breast cancer, (Human) (60 years)      | DNA  | 53                  | 55                  | 63                   | 46                    | 91                     | 53                        |
|   | Agar | 1                   | 4                   | 5                    | 3                     | 6                      | 2                         |
| 4. Breast cancer (Human) (49 years)       | DNA  | 48                  | 47                  | 71                   | 70                    | 65                     | 71                        |
|   | Agar | 2                   | 1                   | 4                    | 5                     | 3                      | 6                         |
| 5. Breast cancer (Human) (43 years)       | DNA  | 41                  | 47                  | 44                   | 85                    | 58                     | 75                        |
|   | SDI  | 57                  | 52                  | 50                   | 23                    | 49                     | 29                        |
|   | Agar | 1                   | 3                   | 2                    | 6                     | 4                      | 5                         |
| 6. Lung cancer, (Human)                   | DNA  | 59                  | 47                  | 71                   | 50                    | 41                     | 88                        |
|   | SDI  | 43                  | 46                  | 31                   | 51                    | 59                     | 18                        |
|   | Agar | 4                   | 2                   | 5                    | 3                     | 1                      | 6                         |

For DNA, the numbers represent percent of control value. The lower the number, the more active the drug against the tissue.

For SDI, the numbers are expressed as percent inhibition of the enzyme. The higher the number, the more active the drug.

For Agar plate assay, numbers represent order of activity,

data have recently become available.

## Materials and Methods

**Agar plate Assays:** The tests resemble antibiotic disc sensitivity tests.<sup>9</sup> Immediately after surgery, each patient's living cancer cells are dissected free of necrotic cancer and normal cells, then minced in complete tissue culture media containing human serum and antibiotics. Results are read by midnight of the day of surgery and within 24 hours of surgery. End point of agar plate assay is activity of the many enzymes reacting with methylene blue.

**SDI, Succinic Dehydrogenase Inhibition, Kondo Test:**<sup>4</sup> The SDI test resembles agar plate assay chemically except that activity of only succinic dehydrogenase is monitored as end point. Drug activity is expressed as percent of inhibition of succinic dehydrogenase activity. The higher the value for a given drug, the more active is the drug against the given cancer cells.

**Radioactive Tracer Studies:** The tests monitor drug effects on tracer incorporation to DNA, RNA and protein.<sup>10</sup> Table 1 shows drug effects on incorporation of tritiated thymidine to DNA, the most significant parameter for the particular drugs listed.

Drug effects are expressed as percent of control values. The lower the value, the more active the given drug against the cancer cells (the exact

from 1-6. The lower the number, the more active the drug.

Oxo-oxophenarsine(mapharsen) plus adjuncts menadiol (Vitamin K), malonate, fluoride and heparin in the ratios used clinically;<sup>5</sup> IAC-iodoacetate plus adjuncts;<sup>9</sup> 5-FU- 5-fluorouracil; Meth- methotrexate; HN-2- nitrogen mustard or Mechlorethamine.

opposite of the Kondo test or SDI test above). Reduction of tracer incorporation to less than 60% of control is usually needed for clinical activity, and preferably less than 55 or 50% of control.

As in all the sensitivity tests used, drug concentrations vary directly with clinically permissible dose levels. Very toxic drugs are tested at low concentrations relative to less toxic drugs.<sup>5,9,10</sup>

**Inhibition of DNA Polymerase Activity of Intact Cells.** A double isotope technique is used to measure inhibition of DNA polymerase activity in intact cancer and normal cells. Control, untreated cells are incubated with a metabolic precursor of DNA (thymidine labelled with tritium or <sup>3</sup>H) and treated cells with a drug and the same metabolic precursor of DNA labelled differently (thymidine labelled with radioactive carbon or <sup>14</sup>C). Control and treated cells are pooled after incubation so both suffer identical losses. DNA and its precursors are separated by chromatography.<sup>10</sup>

The ratios of <sup>14</sup>C to <sup>3</sup>H are determined in a Packard 3375 liquid scintillation spectrometer. Drug inhibition of DNA polymerase activity is seen as a large depression in the ratio to less than 100% of control for DNA, with a large increase in the ratio for thymidine triphosphate, the precursor of DNA.<sup>10</sup>

In this test, drugs are used at 1 mM concentration except for the adjuncts used with drugs

termed SH inhibitors, which react with sulphydryl groups of proteins. Oxophenarsine, an arsenical previously used successfully for syphilis, was the first such SH inhibitor available for clinical use. Adjuncts menadiol, malonate, fluoride and heparin are used clinically<sup>5</sup> and in the tests to extend effects of the drug and minimize use of the active component. Sensitivity tests and animal studies showed that the adjuncts alone show insignificant effects against tumors but do significantly potentiate effects of active SH inhibitors, oxophenarsine and iodoacetate described in columns 1 and 2 of Table 1.

## Results

Agar plate assay, the SDI test, and radioactive tracer studies have agreed with each other in over 85% of cases to date, to indicate active and inactive drugs for clinical therapy.<sup>5</sup> Agar plate assay gives only qualitative orders of activity, while the other two give quantitative data. Because the radioactive tracer studies also give clues on mechanisms of activity, they are becoming increasingly important.

All three tests can, however, rule out with complete accuracy drugs inactive for clinical therapy. This has been true in our laboratories and many others throughout the world.<sup>3-10</sup>

Table 1 shows the effects of a variety of anti-tumor agents on incorporation of tracers to DNA of normal and cancer cells, the most significant parameter for the drugs listed. Where available, data from the SDI test and agar plate assay are given side by side.

Typically, one or more of the clinically useful SH inhibitors (oxophenarsine and iodoacetate) has depressed tracer incorporation to DNA of human and animal cancer cells more than for normal cells, such as liver, leukocytes (shown in Table 1) and wound tissues. Commonly used antimetabolites like 5-FU and methotrexate, and alkylating agents like HN-2, by contrast, have usually shown the reverse undesirable effects: greater activity against normal tissues than cancer. For cancers, a low figure below 50-60% is desirable for DNA and a high figure, above 50-60%, in the SDI test; with the reverse for normal tissues.

Although one or more of the new or old clinically promising SH inhibitors has to date inhibited cancers more than normal, the data cannot be extrapolated to signify that every SH inhibitor is active against every tumor, or more active than against normal tissues. This is the reason for running sensitivity tests on

each patient's own cancer, to rule out inactive drugs of all types, and select from among those showing activity.

The effects are illustrated in Table 1. Thus, for Patient 6, iodoacetate plus adjuncts was much more active than oxophenarsine plus adjuncts, whereas the reverse is true for Patient 5, for example. Patient 6 obtained his clinical regression of lung cancer metastatic to neck nodes from chemotherapy with iodoacetate plus adjuncts. Nitrogen mustard and methotrexate, both active against his tumor, were far too toxic for use in this debilitated patient.

Patient 5 with massive cancer replacing liver, obtained her first regression from chemotherapy with oxophenarsine plus adjuncts. Although 5-FU was active for this patient's cancer, maintenance therapy with 5-FU failed because of toxicity to bone marrow (illustrated in part by marked depression of tracer incorporation to human leukocytes, as seen in Table 1). Her second clinical regression was obtained with a second course of oxophenarsine, then maintained for over a year on iodoacetate plus adjuncts with occasional small doses of 5-FU (about 500 mg/month).

Just as the sensitivity tests have agreed well with data on both active and inactive drugs for mouse tumors,<sup>1,5,6,9,10</sup> they can provide interesting correlations for higher animals. The cat listed in Table 2 was 10 years post menopausal. Against her cancer, Premarin® was the most active drug found, as would be expected for a human patient very many years post menopausal. Eight months after initiation of therapy with Premarin®, the cat is clinically free of evidence of cancer, despite the fact that her cancer was unusually aggressive, having about tripled in size in less than a month. By contrast, for the human cancer patients with breast cancer listed in Table 1, Premarin® was found to be less active the younger the patient.

Only for the 60-year-old Patient 3, ten years post menopausal at the time of radical mastectomy, has any Premarin® been used clinically. Postoperatively, the patient received a course of oxophenarsine plus adjuncts, then has been maintained on iodoacetate plus adjuncts and estrogen. The patient is indeterminate for effects of any one drug. Four years postoperatively, her liver scan, originally interpreted as consistent with multiple small metastases, was diagnosed as showing no evidence of disease.

The 49-year-old Patient 4 was admitted with widespread breast cancer, including metastases to face and scalp. She obtained her first regres-

sion of all scalp metastases on oxophenarsine plus adjuncts. Thereafter, she was maintained for over one and a half years on iodoacetate plus adjuncts along with halotestin. A brittle diabetic, she suffered a fatal heart attack during the night following a day of heavy physical activity.

Just as the SH inhibitors show relatively little effect against leukocytes, they have shown little effect against normal liver and normal healing wounds.<sup>5,10</sup> Clinically they have shown no ill effects on wound healing and peripheral blood counts by contrast with commonly used antimetabolites and alkylating agents which often must be withheld for four to six weeks post-operatively and frequently depress peripheral counts markedly. Clinically, regressions have been obtained in the majority of patients treated with the SH inhibitors, where objective effects of chemotherapy could be measured.<sup>5,9</sup>

Table 2 illustrates a possible reason for the apparently preferential effects seen clinically on some human cancers with the clinically useful SH inhibitors. Here, effects of promising rifamycin antibiotics and SH inhibitors are seen on intact cancer cells from the 43-year-old patient suffering from breast cancer, listed as Patient 5 in Table 1. The clinically promising SH inhibitors (including oxophenarsine on which the patient obtained her clinical regression) markedly inhibit DNA polymerase activity, as seen from accumulation of label in thymidine triphosphate and depression of label in DNA relative to controls, but with much less effect on normal leukocytes.

**Table 2. Effects of Drugs on DNA Polymerase Activity of Intact Normal and Cancer Cells**

| Tissue                                      | Drugs                          | Average Value of $^{14}\text{C}$ : $^3\text{H}$ Ratio as % of Control Thymidine Triphosphate | DNA |
|---|--------------------------------|--|-----|
| Normal                                      | Oxo                            | 156  | 65  |
| Human Leukocytes                            | IAC                            | 160  | 56  |
|   | HN-2                           | 156  | 25  |
|   | Cytosar                        | 216  | 20  |
|   | N-Demethyl-rifampicin          | 162  | 42  |
|   | N-Demethyl-N-Benzyl Rifampicin | 174  | 30  |
| Human Breast Cancer (Patient aged 43 years) | Oxo                            | 210  | 19  |
|   | IAC                            | 204  | 17  |
|   | 5-FU                           | 124  | 131 |
|   | N-Demethyl-rifampicin          | 139  | 49  |
|   | N-Demethyl-N-Benzyl Rifampicin | 83   | 72  |

Abbreviations are the same as those used in Table 1. The greater the inhibition of DNA polymerase activity, the lower is the ratio for DNA, and the higher the ratio for the immediate precursor of DNA, thymidine triphosphate.

The rifamycin antibiotics which have received considerable attention for their ability to depress DNA polymerase activity of oncogenic viruses and human acute leukemic lymphoblasts, by contrast, show much less effect against the intact cancer cells than against normal leukocytes, as has been found with other cancers and normal tissues.

Previously published data have shown that the clinically useful SH inhibitors are also extremely active against DNA polymerase activity from oncogenic virus and human leukemia cells, with activity usually far exceeding that of available rifamycins.<sup>10</sup>

## Discussion

Clinically, the use of sensitivity tests on individual human cancers was started to match cancer chemotherapy with the highly variable requirements seen clinically among patients with cancers of the same histology. Many groups have now confirmed the ability of the sensitivity tests to rule out inactive drugs with complete accuracy.<sup>4-9</sup>

For workers who vary drug concentrations in the tests in accord with clinically permissible dose levels, overall accuracy of the tests for solid tumors has ranged from 61% to as high as 98%.<sup>11</sup> The value of the tests has been seen not only in rates of regression but in survival rates in randomized studies as well.<sup>4-9,11</sup>

Because transformation of normal cells by oncogenic viruses now appears to require altered DNA polymerase activity to transcribe altered genetic information, the ability of the sensitivity tests to select antitumor agents inhibiting DNA polymerase activity of cancer cells might be regarded as a crucial test of the value of the sensitivity testing.

As early as 1967, the sensitivity tests had shown preferential effects of selected SH inhibitors against enough human cancers so that action of the drugs on DNA polymerase activity of cancer cells was anticipated.<sup>6</sup> A deliberate search for the reason for the apparently preferential effect seen by selected SH inhibitors against some human cancers showed that the drugs inhibited markedly DNA polymerase activity from oncogenic virus, from human acute leukemia cells<sup>10</sup> and from a variety of intact human cancer cells, as well. Multiple workers have now noted the promise for rational chemotherapy of drugs inhibiting DNA polymerase activity from oncogenic viruses and leukemia cells.<sup>8</sup>

As a result, the value of sensitivity testing for cancer therapy and cancer research would appear to be adequately confirmed. ▀

## References

A complete bibliography may be obtained by writing the *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago, 60601.

# **Deafness and Acupuncture**

BY MAX S. SADOVE, M.D., KOJI OKAZAKI, O.M.D., SANG IK KIM, M.D.,  
MAN H. LEE, O.M.D., TAK HO LIU, M.D., O.M.D./CHICAGO

With the reopening of communications with China, the Western world heard of the treatment of deafness—even nerve deafness by acupuncture. In movies we saw formerly deaf children sing, dance and play musical instruments. But from that day to this, there have been no significant statistics. There have been no data as to standards of selection; standards of improvement; percentage of improvement; etc.; nothing but the statements and movies that there was improvement; no evidence of a series of control audiograms over a period of time and/or changes produced by therapy in a large enough number of cases to draw a scientific conclusion.

Thus, all reactions were and are totally emotional. Some physicians were totally agnostic; some had complete, total, and irrevocable disbelief; others, the majority, were totally confused. Most physicians could not even guess how to answer the patient inquiries—"Should I try it or not?"; "What are the chances of it helping and harming?" In general, most agree there is relatively little chance of harm. But what of chance of improvement—this was not known and is not known now.

Approximately a year ago, a grandmother called and asked if we would not please treat her grandchild for nerve deafness. We told her we could not without referral and without a consultation by an otologist—and also we doubted that the chances of success were more than 1 to 2500 in our opinion. The answer was somewhat startling—"Make it 1 in 5000 and can we come next week after seeing our other doctor? After all, no one else has anything to offer." This cry has been heard over and over and it must be answered soon.

It is obvious to us all that the chances of charlatanism are astronomical. Also, the chances of harm are not negligible if competent otologists

do not follow these patients. The waste of time and money may also frequently be very significant. In addition, false hope has its psychic harm and that can be markedly injurious. Yet, the question can acupuncture help any form of deafness must be answered. Some have papers in the professional press reporting a negative case. Others have stated after following a handful of cases, that acupuncture is a hoax. Still others have reported changes in less than a handful of cases and made a statistical conclusion. Also, will the usual "acupuncture clinic" know when to look for a cerebellopontine angle tumor? Will antibiotics be discontinued that are being chronically used on the patient and may be contributing or actually causing the deafness? Will the patient be removed from vapors or fumes of toxic agents such as the degreasing agents, cleaning agents, paints, etc., that can be a factor? In most instances these factors will not even be considered by a non-physician group. Is there anything to suggest that the deafness is on a vascular basis (either small or large vessel) that could respond to more logical therapy?

Dr. Fredrik F. Kao and his co-workers from State University of Downstate Medical Center, New York, have reported in the *American Journal of Chinese Medicine* as of July, 1973, the improvement in five patients. This study shows control audiograms and a battery of other tests as well as post therapy audiograms and tests. The evidence of improvement is amazing. This group is highly competent, scientific and current as to the recent changes that are occurring with acupuncture in China. This study forces scientific groups to carefully evaluate their techniques and the minutia associated with their routine. They also force logical investigators to reevaluate their therapy and continue to investigate acupuncture as a mode of therapy for deafness.

## **Activities of the Pain Clinic**

Approximately two years ago, we decided that acupuncture should be studied for its usefulness in management of pain. This we concluded because a dear friend, Professor M. Hyodo, Medical College of Kyoto, found acupuncture useful in his pain clinic. Approximately one third of all

MAX S. SADOVE, M.D., is Professor and Chairman of the Department of Anesthesiology, Rush Presbyterian-St. Luke's Hospital, Rush Medical College and Physician Coordinator of the Rush Pain Center, Chicago. SANG IK KIM, M.D., is Assistant Professor in the Department of Anesthesiology at Rush Medical College and Assistant Physician Coordinator of the Rush Pain Center. KOJI OKAZAKI, O.M.D., MAN H. LEE, O.M.D., and TAK HO LIU, M.D., O.M.D., are acupuncturists at the Rush Pain Center.

the referred pain problems were treated with acupuncture in his clinic even though this group had available all the common drugs of Japan; also, they were extremely competent in the use of all the common regional techniques. Dr. Hyodo was invited to Rush-Presbyterian-St. Luke's Medical Center. Our plans were submitted to our peer groups and approved. Being skeptical at the time as to its value to the patients, no charges were made for therapy. The staff was notified of our activities and immediately an excess of patients was available. After three months of activity, the study was stopped and our activity evaluated. There was an inescapable conclusion—acupuncture served a useful place in the management of pain problems and also studies were justified in many other disease syndromes.

Additional space was obtained, additional personnel added and a center organized that consisted of a minimum of two doctors of Oriental Medicine and two M.D.'s in addition to varying numbers of residents, interns and visiting physicians. All patients were and are referred by physicians. A consultant group was formed and organized and provision was made for hospitalization of those requiring that action. Approximately 600 to 700 patients per month have been treated by a team of five people. A minimum of two physicians and also a director is available at a moments notice, being the basic unit.

It was annoying not to be able to answer the question as to the effect of acupuncture on deafness. In the initial group, we simply refused to try this technique, but in early months of study, we noticed that tinnitus and vertigo were frequently improved in patients with headaches and menieres disease and in patients where tinnitus was a primary complaint.

We concluded that if acupuncture clinically improved patients suffering from tinnitus and vertigo, it might help deafness. Requests were being made for therapy for deafness. We attempted to have all patients seen in our own ear service but some came with complete work-ups including recent audiograms, and it was occasionally not repeated but follow-ups were strongly encouraged.

### Results

Thirty patients have been treated, none have shown a definite (10% or more) increase in the audiogram. More than one third of the patients have an impression that their auditory discrimination was better. Such things as a hearing aid seemed to work better, as do phone amplifiers or the phone itself, or television. Noises, either

internal or external, are diminished in approximately 25% of those who have this symptom. Curiously almost all of these patients state that the noise is at a lower pitch and shorter duration or as they describe it, the noise is milder. This number is too small to justify a statistical type conclusion or even a clinical conclusion.

### Discussion

We have concluded that a technique that is less than maximal is not justified at this time. We are forced to conclude that the old classical treatment as well as some of the more recent therapy must be extended in its duration. This technique of increasing the duration of effect is becoming more frequent in China. The peripheral points are being used less frequently and a routine such as chromic catgut is being placed intradermally at the newer acupuncture points or the intra-dermal needles may be used in place of the suture. This would diminish overall cost in that the patient would be treated less frequently. These patients must be carefully evaluated prior to therapy also a careful and complete battery of tests must be included. The pattern of evaluation of Dr. F. F. Kao, et. al., seems to be an excellent one.

However, this study might be more easily performed in a school or several schools for the deaf. Thus, this could be done to a significant number of people by this approach in a relatively short time and controls could be carried out relatively easily. By training of local nurses in this one technique, the cost can be kept to a reasonable level. A panel of experts, primarily otologists, including statisticians, public health experts, etc., should help plan and evaluate results.

Simply accumulating a small series in a few places in the nation will not stop the hope, true or false, nor will it stop the exploitation or dabbling. The true scientist has little choice but to search for the truth.

### Conclusion

At present, after almost two years of limited activity in acupuncture therapy for deafness by the classical technique, we can make no statement but that we have failed in our initial activity to significantly improve patients. However, we are not satisfied and we can not stop. We must study the new and more intensive techniques in all fairness to reach a correct conclusion. We sincerely believe that this must be studied in an adequate number of patients, preferably in a number of our state institutions or by a state or philanthropically sponsored study group. ▲

# Improving Medical Service in Long Term Care Facilities

BY BERTRAM B. MOSS, M.D., CHICAGO; AND MICHAEL A. WERCKLE, M.D./SPRINGFIELD

A skilled nursing home must have a medical director either on a full-time or consultant basis and an intermediate care facility must have a physician provide continuing supervision, see residents as needed, and in no case less than quarterly, unless justified otherwise and documented by the attending physician.

A medical director's first responsibility is to patient care, and he should not be encumbered with too many "administrative" duties. He should oversee any aspect of the nursing home operation that has a potential effect on patient health, such as dietary service, housekeeping and maintenance. A medical director must define his duties to his own assessment of the circumstances prevailing in a given facility and should not be held to a rigid job description.

The AMA's Committee on Aging has drafted a preliminary statement on the medical director's role. It said, "a medical director should be retained by a facility's governing body, with the approval of the organized medical staff if one should exist. The amount of time spent carrying out the specified duties of a medical director should be independent of the time spent providing direct patient care. The compensation for the medical director should *not* be in the form of patient referral or consultation."

The AMA committee suggested that a medical director should:

1. Assist in arranging for continuous physician coverage for medical emergencies and in developing procedures for emergency treatment of patients.
2. Participate in development of a system providing a medical care plan for each patient, which covers medications, nursing care, restorative services, diet, and other services, and, if appropriate, a plan for discharge.
3. Be the medical representative of the facility in the community.
4. Develop liaison with attending staff physicians in efforts to ensure effective medical care.
5. In the absence of an organized medical staff, be responsible for the development of written by-laws, rules and regulations applicable to each physician attending patients in the facility.

BERTRAM B. MOSS, M.D., is Chief, Geriatrics Program Development, Illinois Department of Public Health, Office of Health Facilities and Quality of Care. At the time of writing, Dr. Moss was Executive Director, Park View Home, Chicago. M. A. WERCKLE, M.D., is Associate Director, Illinois Department of Public Health.

6. If there is an organized medical staff, be a member, attend meetings and help assure adherence to medical staff bylaws, rules and regulations.
7. Participate in developing written policies governing the medical, nursing, and related health services provided in the facility.
8. Participate in developing patient admission and discharge policies.
9. Participate in an effective program of long-term care review.
10. Be available for consultation in the development and maintenance of an adequate medical record system.
11. Advise the administrator as to the adequacy of the facility's patient care services and medical equipment.
12. Be available for consultation with the administrator and the director of nursing in evaluating the adequacy of the nursing staff and the facility to meet the psychosocial as well as the medical and physical needs of patients.
13. Be available for consultation and participation in in-service training programs.
14. Advise the administration on employee health policies.
15. Be knowledgeable concerning policies and programs of public health agencies which may affect patient care programs in the facility.

Doctors comprise 3% of all employees of long-term care facilities. Today, the number of facilities has grown, but the proportion of medical house-staff remains relatively small. Doctors must be encouraged to serve patients in long-term care facilities.

It is a general feeling that doctors will not become medical directors in large numbers until appropriate reimbursement makes the rewards of such positions competitive with private practice. If the nursing home hires a physician or finds some means of carrying out the required functions of a medical director, then those become allowable expenses of the nursing home, and should therefore become part of the reimbursable rate.

Discrepancy between the amount of reimbursement, and the salary necessary to attract medical directors on a large scale, might encourage some nursing homes to continue to operate without medical directors. The services of a medical director could be secured by the home if the AMA's tentative prohibition against compensation in the form of patient referrals and the Illinois Department of Public Aid restriction against supplemental care are both compromised. The problem of compensation is more serious for

nursing homes with fewer than 200 beds. Larger institutions appear more inclined to afford full-time medical directors.

Physicians may eventually be ethically permitted to join together with a nursing home and accept on a per capita basis, a payment for the total care of all assigned public aid recipients. Basically, the proposal is for physicians under a single supplemental payment plan to provide total medical care to an assigned patient from moment of admission to discharge, transfer or demise.

A medical group could serve the patients in several long-term care facilities and create a medical staff equivalent that would serve several nursing homes in the community. The medical group and the nursing homes could cooperate to establish:

1. an executive committee composed of physicians and administrators;
2. a medical audit committee consisting only of physicians;
3. a procedural review committee composed of administrators and physicians and directed by a physician; and
4. a utilization review committee of physicians, and other professionals.

This alliance would increase the interest, communication and active participation of community physicians in the affairs of long-term care facilities, and result in improved quality of medical and nursing care. Quantity of care must never be substituted for quality. Quality care implies its application at the right time and in proper quantity.

Skilled and intermediate care facilities should be encouraged to provide parallel or alternative community-oriented services such as home health and geriatric day care. The adoption of H.R.I is almost as important as the inception of Medicare, and will drastically increase the significance of nursing home medical directors. Physicians in long-term care facilities must be prepared to be knowledgeable and make full use of the parallel services and alternatives to institutional care.

The *short-range objective* of the AMA proposed program is to prepare physicians to serve as medical directors in intermediate and skilled homes, and to upgrade the skills and knowledge of those who now serve in such posts. The *long-range goal* is to establish permanent state medical society committees on Aging to have continuing responsibility for supplying and upgrading medical services in the homes. This will result in an

increased supply of physicians willing and capable of serving nursing homes as medical directors.

### **Physician Services Arrangements**

There are four basic types of arrangements for Physician Services in nursing homes:

1. Employment of a full-time on-call physician, with a designated alternate.
2. Arrangement for a physician to come to the home at regular and periodic intervals.
3. Arrangement for a physician to come to the home when needed but not at regular intervals.
4. Arrangement for a physician to give medical care to the residents of the home in his own office.

The majority (54%) of all the nursing homes serving residents in 1968 arranged to have a physician come to the home when he was needed but not at regular intervals, with 34% having a physician to visit the home at regular intervals; 7% employed a full-time physician, 2% arranged for office visits, and the remaining 3% made no arrangements for physician services.

Virtually all of the homes arranged for physician services, but most of the arrangements dealt with treating the patient after he became ill. Only those homes which had a full-time staff physician visit regularly (34%) offered the chance of preventing an illness from occurring; 47% of the homes with over 100 beds arranged for a physician to visit the home regularly; and 15% employed a full-time physician to come when needed.

### **Preventive Medicine**

Responsible medical directors should help alleviate some of the major medical problems of long-term care facilities if they will practice *preventive medicine*. The cost of preventing illness (or its complication) should be as reimbursable as the cost of treatment of existing illness. The moral and economic incentive must be to keep patients well, rather than to only treat the sick. Control will be assured by having a responsible medical director. Nursing home staffs must not operate only with a reimbursement motive. Sick residents of homes should not be capitalized on and viewed as potential dollars rather than sick human beings. We need clear

policy with regard to the infirm or confused elderly with quality care and their individual needs being assigned the highest priority.

We urgently need *more properly trained personnel* as well as *more physician participation* with definite responsibility in long-term care facilities. A reimbursement system is needed which provides a fair rate of return for the well intended operators and physicians to provide good environmental social and preventive medical care. Regulatory agencies must accredit institutions not solely on the basis of physical requirements but on demonstrated quality of patient care. Long-term care facilities will be thought of as a last recourse and not the easy solution for elderly persons troubled by less than perfect health or some unmet social need, as soon as alternative and parallel services are available.

Far reaching efforts have been made in the last few years to break down the difference between "service" (ward) patients and private patients. In many instances this has included equal physical facilities for all patients. Large wards have been renovated into two and four bed units and in new construction no units larger than four-bed will be built. Staff should not be able to distinguish between private and non-private pay residents and must give *equal care and service to all* as evidenced by frequent chart notes, and contact with the patient and his family.

We need some form of insurance, similar to what we have for hospitalization, for those who require nursing home care. In Illinois, there are currently less than 30% private-pay residents in long-term care nursing facilities. The remaining 70% are subsidized by State public aid. We must settle for nothing less than one class of quality care for our elderly who have outlived their money or their families. Many of them are victims of inadequate retirement or pension plans, and most of them are victims of our inflation.

The most critical *unsolved health problems* that confront all of us entail social and environment factors that are totally avoided or neglected. These include preventive health methods, mental disorders, behavioral aspects of health maintenance, geriatric and other chronic illnesses, difficulties in access to health care, and the effects of poverty on health. We are specifically concerned about the elderly who are incapable of helping themselves. The greatest percentage of impoverished old and often confused persons still live in the general community. Of the approximately 5% who are institutionalized in Illinois, about 70% receive public financial aid. The number of

elderly persons and their life span will increase, and their needs will also increase.

A major mistake has been the assumption that the responsibilities of health care professionals began and ended with biologic research and its application to individual patients. The social problems relative to health care are chief of those yet unsolved. Our academic health centers have yet to establish any over-all health research policy, to evaluate adequately the benefits and costs of clinical procedures, and to take an active interest in patient-care or research for the aged. Another major error is the insistence by regulatory agencies of detailed written documentation of the delivery of care and service. This can only be accomplished by the very few available professionals already over-burdened with direct patient care and service. Surveyors should be sophisticated enough to be able to evaluate the quality of care and service actually performed, and free professionals from the required documentation. Until we develop enough trained and experienced professionals to care for patients in long-term care facilities, we must be content with proper care and service rather than written documentation.

Ten percent of our population is above 65 years of age, and the percentage is increasing. We cannot solve their problems without the help of experts in many other nonmedical fields. New kinds of people must be immediately recruited and trained, and new community and institutional arrangements made. Priorities must be established to recognize the *needs* of the elderly as primarily financial; secondarily, the inability to cope with psycho-social components of life; and then the unavailability of the skills of geriatric-health-care professionals to care for their needs.

### Need For Autonomous State Department

*Each State must have its own autonomous department concerned with providing care and services to the elderly.* Staff of this department must be knowledgeable about old persons, their needs, and how to provide what is the best available for them in the community and in institutions.

The main thrust of care for the elderly by the government must be directed toward:

1. a greater emphasis on continuous accessible outpatient community prevention care and treatment; and
2. A more efficient operation and utilization of health facilities.

The minimum standards requiring physician visits to residents for long-term care facilities and the fees paid for these visits is totally inadequate. The motivation of government in setting such inadequate standards for physician visits was based on concepts to avoid over-utilization of medical services. Rather than over-utilization of medical services by patients in long-term care facilities, a computer survey in Illinois in 1972, showed that only 70% of physicians were in compliance with the rules on visits and medication reviews. Another 15% were shown as having "minor" irregularities, and another 15% were "significantly" deficient. Physicians who accept patients needing long-term care, and then fail to provide it, are a main cause of poor care and possible nursing home licensure revocation. Twenty percent of the violations of promulgated minimum standards of long-term care facilities were due primarily to non-compliance of medication review by physicians.

It is the prime responsibility of the attending physician to determine the need for physician visits for each resident. This need must also be a commitment shared by families and residents of long-term care facilities as well as by the Department of Public Aid which pays for needed medical services.

Immediate action is required to provide the quantity and quality of nursing home care that will prevent deficiencies in nursing home professional attendance and inadequate review of medications. State Medical Societies should have their Committees on Aging take immediate appropriate action to insure that:

1. Every licensed nursing home patient has an active attending physician, who acknowledges his continuing responsibility in writing;
2. Every such attending physician assumes adequate responsibility for finding and designating an alternate in the event he cannot fulfill this professional obligation;
3. In the event attending physicians fail to properly exercise either of their responsibilities, medical directors and licensed nursing home administrators take prompt and appropriate action through local societies to obtain active attending physicians;
4. All physicians, patients and responsible family plus responsible

state agencies are fully informed regarding these requirements and are fully consulted prior to undertaking any of the foregoing arrangement;

5. All interested parties are promptly informed regarding the identity of attending physician's status; and
6. Local medical societies accept full responsibility for enforcing all of the foregoing through peer review and other appropriate committee activity.

It does not necessarily follow that if physicians do become part of an employed profession, they will lose much of their control in medical policy-making.

Physicians do not always need non-medical administrators to manage the business end of their profession and to determine how medical care can best be delivered. Help in the delivery of medical care can come from non-physicians. Properly used, their services may lessen the load on the physician's time. Administrators must see their roles as supporters of the physician and should not take over and administer medical programs.

### **Summary**

The nursing home must not profit by rendering poor warehousing care instead of quality socio-medical nursing care. No one should be subjected to long-term care institutionalization if there is a proper alternative. Society must commit itself to a definite policy with regard to the care and treatment of our infirm and elderly before any profession can profess their own policy. Adequately trained and experienced professionals must become a realistic fact in caring for the aged before we can state that true professionals can deliver or supervise the care in nursing homes. No profession should permit its disciples to neglect, abandon, tolerate inadequate or improper care or poor supervision, of old people in long-term care facilities. The final responsibility must be shared by all the licensed professional personnel in the homes. We must correct our cultural myths and misconceptions about the elderly and find cures for the social and physical, illnesses of old age. We must understand the aging process. Perhaps we can then prevent the ego-damaging anxiety, depression and other adverse physical and emotional responses all too prevalent among the aging population. ▶

## Pediatric Perplexities

Ruth Andrea Seeler, M.D., Editor

# Meandering Catheter

By VIVIAN J. HARRIS, M.D., Director

Department of Pediatric Radiology, Cook County Childrens Hospital and  
Hektoen Institute For Medical Research

Indwelling catheterization of the umbilical artery or vein is frequently a necessary procedure in the newborn infant with respiratory distress in order to monitor the ventilatory and metabolic status. Umbilical catheters can also be used for infusions, transfusions and cultures. Although not without some risk to the patient, this is largely responsible for current improvement in neonatal care.

Proper localization may be estimated by clinical methods but is best determined by roentgenograms of abdomen.<sup>1-4</sup> With use of such roentgenograms the catheter can be placed in the safest location; in external iliac artery for umbilical artery catheters, just below diaphragmatic leaflet for venous catheters. In the latter instance the catheter will be in the ductus venosus-inferior vena cava segment.<sup>1,3,5</sup>

### Anatomy

The umbilical vein ascends from the umbilicus in the free edge of the falciform ligament towards the porta hepatis when it enters the left portal vein (Figure 1). Several branches are given off to the quadrate and left lobes of the liver; the course of the vein is extrahepatic. The ductus venosus is a branchless shunt which arises opposite to the umbilical vein outlet, and passes along visceral surface of the liver, empties into the left or middle hepatic vein, very close to their entry into the inferior vena cava.

The umbilical arteries pass inferiorly on the side of bladder, cross the distal ureters and then turn superiorly to join internal iliac arteries. These ascend to the common iliac which go medially and superiorly to abdominal aorta.

### Case Reports

Catheters especially those used for infusions, inadvertently left in undesirable locations, can

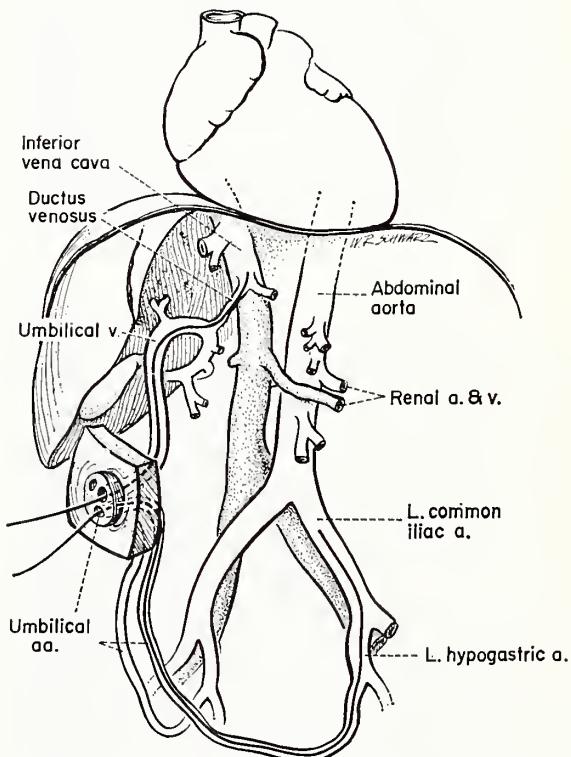


Figure 1. Umbilical artery and vein in the newborn. Catheters are shown in ideal locations.

contribute to life-threatening situations for the patient. Incorrect placements are common and easily re-positioned when recognized. Representative example of problems encountered with poor catheter positions are briefly presented.

*Case 1:* This premature female was born after 34 weeks gestation with a birth weight of 3 lbs. 14 ozs., and had an apgar score of 4. She had many malformations including flexion deformities of the wrists and fingers of both hands, internal rotation of the feet, kyphoscoliosis of the spine and an easily palpable horseshoe kidney. An umbilical venous catheter left in the liver for

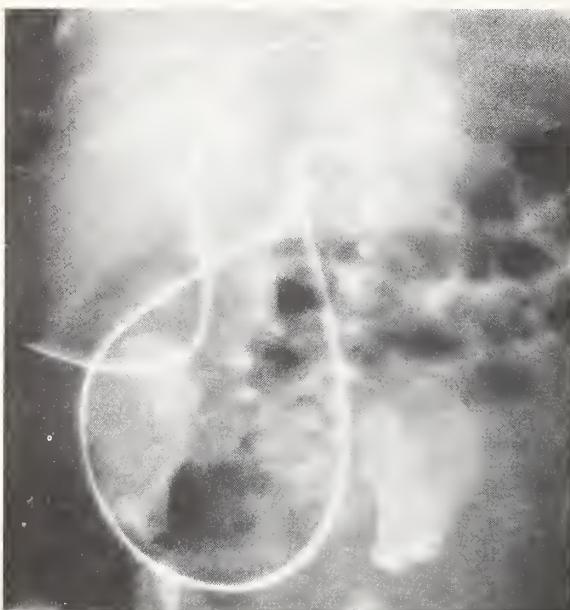


Figure 2. An umbilical venous catheter utilized for an intravenous pyelogram. On the first roentgenogram after the injection of contrast there is opacification of hepatic lobules.



Figure 3. An umbilical venous catheter has been introduced into the heart and lies transversely crossing the tricuspid valve twice.

infusion was utilized for an intravenous pyelogram. Initial film showed massive opacification of hepatic radicles (Figure 2). Subsequent films

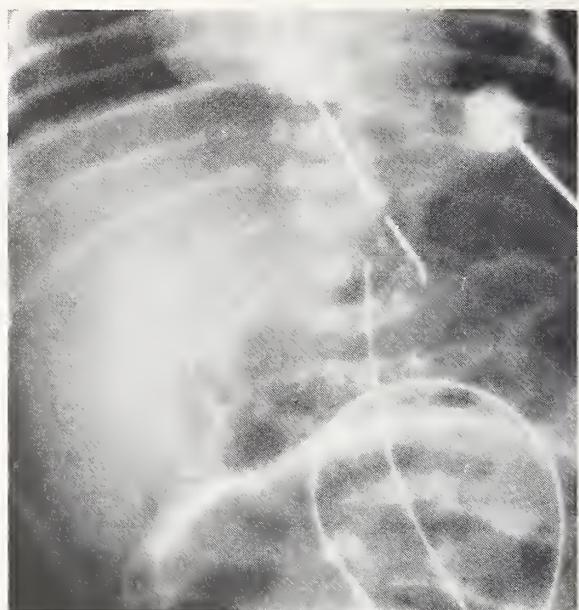


Figure 4. An umbilical artery catheter is in place with its tip at the level of  $T_{12}$ . There is evidence of free air in the peritoneal cavity with air surrounding the liver, separating the bowel loops and outlining the falciform ligament.

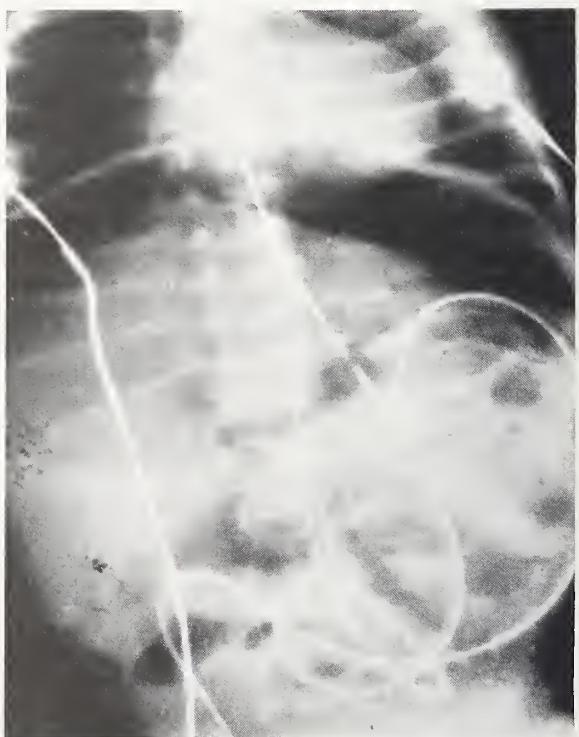


Figure 5. An upright view of the same patient as in Figure 4 confirms the presence of free air, under both diaphragmatic leaflets.

demonstrated a horseshoe kidney and strictures of the uretero vesical junction bilaterally. She developed respiratory stridor due to paralysis of

the vocal cords and required a tracheostomy. The infant went steadily downhill and died. An autopsy was performed.

**Comment:** There is a potential danger of liver abscess when a catheter left in region of liver is used for infusion of hypertonic solutions. At autopsy, no liver abscess was present, however, there was infiltration of chronic inflammatory cells around the periportal area and acute inflammatory cells replacing the liver cells.

**Case 2:** The patient was a 3 lb. premature with an apgar score of 10 at birth. Within two hours the infant developed respiratory distress with grunting respirations, and gradual onset of rapid respiratory rate and cyanosis. An umbilical venous catheter placed for electrolyte and blood gas monitoring, is seen within the heart, crossing the tricuspid valve and recrossing to re-enter the right atrium (Figure 3). The roentgenogram also confirms the clinical diagnosis of hyaline membrane disease. Despite use of 70% O<sub>2</sub>, grunting spells and retractions became worse. Heart rate was 170/min. with no murmurs audible. The infant developed bloody urine, apneic spells, shallow breathing and increasing cyanosis and died at 15 hours of age.

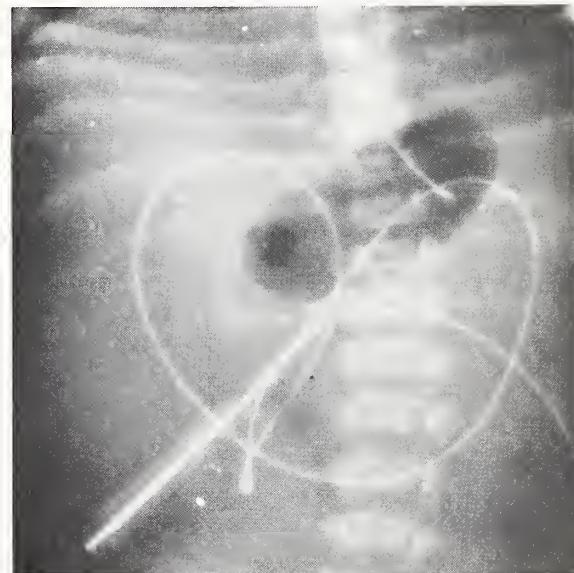
**Comment:** If a stiff catheter is used the effect of this may produce tricuspid insufficiency by holding valve open, but there is generally no valve damage with the polyethylene catheters in use today. Other possible complications include thrombosis and perforation.

**Case 3:** This female infant was 28 weeks gestation, weighed 2 lbs. 5 oz. at birth and had an apgar score of 6. She developed grunting respirations and retractions shortly after birth. Umbilical artery catheterization was done on day of birth and used for intravenous fluids, blood gases and electrolytes. She did well until the 11th day of life when she developed apneic spells and lethargy. On the 12th day the abdomen became distended. She had a normal small stool that day; bowel sounds were hypoactive. Supine and upright views of the abdomen showed free air in peritoneal cavity and thickened bowel loop walls (Figures 4 & 5). Laporatomy revealed a mesenteric thrombosis necessitating resection of 50% of the small bowel. The infant succumbed two days later. At necropsy thrombosis in aorta, renal, superior mesenteric and left iliac arteries were found (Figure 6).

**Comment:** Umbilical catheters should always be removed as soon as possible. Despite the most diligent care including use of the least thrombogenic material, flushing or infusion with heparinized saline and pressure monitoring there still remains a risk of thrombosis. Free air in the peritoneal cavity indicates that bowel supplied



**Figure 6.** Autopsy specimen of the thrombosis in abdominal aorta shows extensive course. Same patient as shown in Figs. 4 and 5.



**Figure 7.** The umbilical venous catheter is seen turning toward the left and crossing the abdomen transversely. The tip is in the lower left abdomen.

by arteries involved has become necrotic and perforated.

**Case 4:** This infant was a 40 week gestational age female with birth weight of 5 lbs. 16 ozs. She was a floppy baby with odd facial appearance and weak cry. Ears were small, low set and peculiarly rotated. There was microphthalmia, enophthalmos

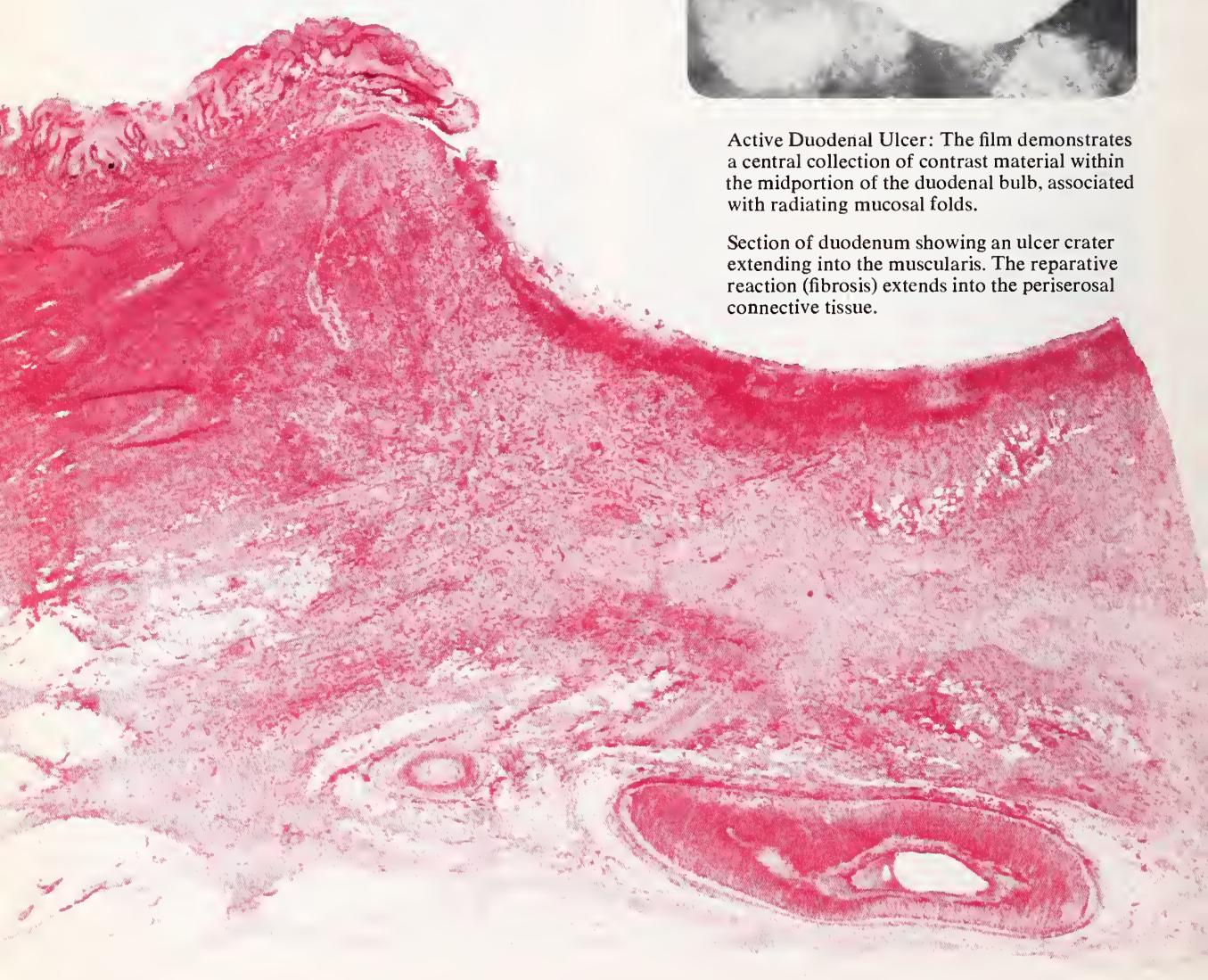
(Continued on page 116)

# Status Symbol



**Active Duodenal Ulcer:** The film demonstrates a central collection of contrast material within the midportion of the duodenal bulb, associated with radiating mucosal folds.

Section of duodenum showing an ulcer crater extending into the muscularis. The reparative reaction (fibrosis) extends into the periserosal connective tissue.



# ...duodenal ulcer— his price for recognition

The diagnosis of this overachiever was duodenal ulcer. The prognosis was excellent until the patient received his promotion to department manager. Then his efforts to prove himself by setting impossible goals resulted in overwork, frustration, tension and undue anxiety for both him and his staff. As his physician knows, this excessive tension and anxiety to achieve unrealistic goals might not be without high cost—an exacerbation of his duodenal ulcer.

## The patient who needs adjunctive therapy that provides dual activity

The ulcer patient often presents a special twofold problem—increased gastric secretions and hypermotility plus associated undue anxiety. These two factors may adversely affect the healing process. This is where adjunctive, dual-action Librax® may often help.

## Librax—specifically formulated for dual action

Only Librax provides, in a single capsule, the special dual activities of these components: the antianxiety action of Librium® (chlordiazepoxide HCl) and the antisecretory/antispasmodic action of Quarzan™ (clidinium Br). When undue anxiety contributes to the exacerbation of duodenal ulcer symptoms, dual-action Librax is often a highly useful therapeutic addition to the regimen.

## Up to 8 capsules daily in divided doses

For optimal response, dosage should be adjusted to your patient's requirements—1 or 2 capsules, 3 or 4 times daily. Rx: Librax #35 for initial evaluation of patient response to therapy. Rx: Librax #100 for follow-up therapy—this prescription for 2 or 3 weeks' medication can help maintain patient gains.

For the anxiety-linked  
symptoms of duodenal ulcer

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders; and as adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis, and mild ulcerative colitis.

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
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adjunctive  
**Librax®**

Each capsule contains 5 mg chlordiazepoxide HCl  
and 2.5 mg clidinium Br.

## Meandering Catheter

(Continued from page 113)

and hypertelorism. Palate was highly arched and cleft. A grade III/IV systolic murmur was auscultated at left sternal border. Second and fifth fingers overlapped; there were rocker bottom feet and bilateral calcaneo valgus deformities. The multiple malformations were attributed to a trisomy 18.

An umbilical venous catheter is seen to be in an unusual location, crossing the abdomen transversely with its tip lying in the peritoneal cavity (Figure 7). Death at 48 hours of age was related to this catheter complication; at autopsy 100 cc blood was found in the peritoneal cavity from the umbilical catheter which had ruptured through the vein.

*Comment:* An unusual position of the catheter which does not follow the course of known vascular channels should suggest possible perforation via an umbilical vessel into the peritoneal cavity.

### Discussion

Complications of indwelling catheters are primarily due to catheter position, timing and catheter material. Other factors include catheter size, pH and tonicity of infused solutions.<sup>2</sup> Among complications which have been described are thrombosis, embolization, vasospasm, vessel and bowel perforation, hemorrhage, liver necrosis and abscess, delayed portal vein thrombosis, cardiac arrhythmias, perforation of left ventricle, paraplegia, breakage of catheters and infection.<sup>2-13</sup>

Arterial and venous thrombosis comprise the most serious and common complications. Wigger, reviewing 177 neonatal catheterized patients, reports a high incidence of 12% autopsy proven catheter-related thrombosis.<sup>12</sup> Neal, et al. describe a surprising 95% incidence of thrombosis formation demonstrated by hand injection of contrast material at time of catheter removal.<sup>7</sup> Factors involved in production of thrombosis include mechanical alterations in blood flow and period of time catheter is left in place. No relationship between the duration of catheterization and occurrence of arterial thrombi has been established. However, mechanical alterations in blood flow induced by the rough surfaced, thrombogenic, polyethylene vinyl and polyurethane catheters in current use, are thought to be strongly related to thrombus formation. Reported lesions correspond to level of insertion of the catheter and have been described in the umbilical, renal, common iliac arteries and aorta. Proper positioning is vital since unavoidable thrombi and emboli related to catheter placement need not be life-threatening if the catheter

has been properly placed. Emboli which are thrown off will go downstream so that placement of the tip of the catheter distal to origin of major vessels is exceedingly important.<sup>5,7</sup>

Thrombosis or emboli may be accompanied by organ infarctions and death. Umbilical venous catheters are particularly dangerous in this respect if associated with either umbilical infections or infusion of hypertonic solutions into the portal system; this may result in portal vein thrombosis and subsequent portal hypertension. Because of the potential hazards of thrombosis the tip of catheter should never be allowed to remain in either the umbilical vein, intrahepatic or extrahepatic portal veins or cardiopulmonary system. Hypertonic fluids at unfavorable pH, or toxic bacterial products introduced directly into the portal veins may produce actual liver necrosis. Direct infusion of hypertonic glucose or bicarbonate solutions can also be potentially hazardous to other organ systems.<sup>5</sup>

Catheters coiled within the heart have multiple potential dangers; thrombosis, cardiac arrhythmias, damage to cardiac valves and perforation of the myocardium. There has been one report of a perforated ventricle due to umbilical catheter.<sup>10</sup>

Other perforations, of umbilical vessels or intestine have been recorded. When the catheter follows an unusual course into the peritoneum, perforation of an umbilical vessel can be suspected. If promptly withdrawn there is a good chance for complete recovery.<sup>9</sup> Positioning in a branch of the portal vein should not be misinterpreted as a perforation, although this in itself is an undesirable location. Vascular perforations are related to the use of sharp beveled catheters and may be prevented by using catheters with rounded tips.<sup>9</sup> Perforations of the intestine were originally described incident to umbilical catheterization for exchange transfusions, probably related to the catheter tip in the portal vein disturbing blood flow and pressure sufficiently to produce venous spasm and hypoperfusion with subsequent necrotizing enterocolitis and perforation.

### Summary

Umbilical catheterization of newborns should be done on carefully selected patients who require constant monitoring, infusions or exchanges. Ideal positioning of the catheter is vital to help prevent complications and must be checked by roentgenograms. Catheters should be promptly removed when no longer needed or if there is any complication. ▀

### References

A complete bibliography for "Meandering Catheter" may be obtained by writing to: *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago, 60601.

# practice management



## *The Professional Corporation—Advantages and Disadvantages*

BY WAGDY SHARKAS, CPA, Ph.D/CHICAGO

The professional corporation, by definition, is a professional business entity intended to provide professional services. The controversy of whether a physician or a group of physicians should incorporate is still subject to confusion and misunderstanding. On one side, incorporation is encouraged by the salesmen of retirement plans. On the other side, attorneys and accountants are still in a state of uncertainty as to which course of action is advisable. As such, the question of incorporation represents a critical area of concern for a large segment of the medical profession.

It is the physician's sole responsibility to decide upon whether or not to incorporate. In so doing he must weigh carefully the advantages and disadvantages of incorporation. The objective of this article is to examine thoroughly the advantages and disadvantages of incorporation under present tax laws and sound business logic.

### **Advantages**

In choosing between the corporate or uncorporate form of practice, physicians should be aware of the following advantages of incorporation:

1. *Limited Liability:* It is legally established that the liability to injured parties and third parties cannot exceed the assets of an incorporated practice, whereas the unincorporated practice liability could extend beyond

WAGDY SHARKAS, CPA, Ph.D., Assistant Professor of Accounting at the University of Illinois, Chicago Circle. Dr. Sharkas is a member of the American Institute of Certified Public Accountants, American Accounting Association, National Association of Accountants, Financial Executive Institute, and the American Institute of Decision Sciences.

the practice assets to include all personal assets of the individual physician and all of his partners, if any. As a general rule, the hardship of liability for malpractice on the part of the physicians is usually covered by liability insurance, but the possibility always exists that enough insurance coverage may not be maintained.

2. *Retirement Plans:* Unincorporated practitioners are limited to a retirement plan contribution of 10% of their income but not exceeding a maximum contribution of \$2,500. An incorporated practice can contribute as much as 25% of its covered salaries (payroll) without a maximum limitation. As a matter of fact, an incorporated practice, under the carryover provisions of section 404(a)(7) of tax laws, can contribute up to 30%.

3. *Fringe Benefits:* Physicians must consider the several fringe benefits available to incorporated practice. An incorporated practice can pay tax deductible premiums for disability, and health and life insurance on the lives of its employees (physicians) and their dependents. Other tax deductible fringe benefits available to physicians of incorporated practice are: sick pay exclusion, \$5,000 death benefit exclusion paid to a beneficiary, coverage under workmen's compensation, and disability insurance plans. In considering the effect of the fringe benefits on whether to incorporate or not, physicians must evaluate them collectively. The fringe benefits individually are small items and usually produce immaterial differences to be considered.

**4. Dividend Income Benefits:** Unincorporated physicians are taxed in full minus \$100 exclusion on dividend income from their investment in stocks (preferred and common). An incorporated practice is exempt from taxation on 85% of dividends received on the corporation's investments in domestic stocks. For example, if an incorporated practice owns stocks in General Motors and received \$10,000 in dividends from General Motors, it has to pay taxes on only \$1,500 of the \$10,000. The advantages of incorporation can be exhibited in a simplified comparative cash flow statement as follows:

**Exhibit 1**  
**COMPARATIVE CASH FLOW STATEMENT**

|   | Unincorporated<br>Practice | Incorporated<br>Practice |
|---|----------------------------|--------------------------|
| <b>Net Income From Practice</b>   | <b>\$50,000</b>            | <b>\$50,000</b>          |
| <b>Less: Allowable Retirement Plan Deduction</b>  | <b>2,500</b>               | <b>9,600</b>             |
|   | <b>\$47,500</b>            | <b>\$40,400</b>          |
| <b>Less: Fringe Benefits</b>  | <b>-0-</b>                 | <b>4,000</b>             |
|   | <b>\$47,500</b>            | <b>\$36,400</b>          |
| <b>Less: Federal Income Taxes</b>   | <b>15,810</b>              | <b>10,972</b>            |
|   | <b>\$31,690</b>            | <b>\$25,428</b>          |
| <b>Less: Amount Needed After Taxes to Provide Same Coverage As Incorporated Practice:</b> |                            |                          |
| Retirement Plan   | 7,100                      | -0-                      |
| Fringe Benefits   | 4,000                      | -0-                      |
| <b>NET AVAILABLE CASH:</b>  | <b>\$20,590</b>            | <b>\$25,428</b>          |

*NOTE: The above exhibit assumes that all available cash is withdrawn in form of salary, the practice is owned by a married physician with no children, and no standard deductions and exemptions. Nonetheless, Exhibit 1 illustrates the physician with extra \$4,838 in cash under incorporated practice. In other words, incorporated practice provides 9.68% more spendable cash on net income of \$50,000. That is not to say that this rate is constant. On the contrary, the rate of more spendable cash will increase progressively with the net income increase.*

**5. Continuity of Life:** The death or incapacity of the practitioner does not effect the life of the incorporated practice. An incorporated practice's life depends on its charter, not on the life of its owner(s). An incorporated practice has better chances for continuing either through sale to an outsider physician or through a buy-sell arrangement with other physician-owners of the incorporated practice.

**6. Use of a Fiscal Year:** This factor is not a major consideration to decide whether to incorporate or not. Yet, there may be some initial tax savings as a result of change from a calendar year to a shorter fiscal period. Also, the use of a fiscal year would

give the physician and his accountant the freedom of selecting the date of year-end whereby they can devote more time to year-end tax planning.

### Disadvantages

For a physician to decide upon whether or not to incorporate, disadvantages of incorporation should be evaluated carefully. The main disadvantages of incorporated practice could be summarized as follows:

- 1. Requirements of Incorporation:** There are some initial legal and accounting costs unavoidable upon incorporation. In addition to these initial costs, annual costs in form of fees will be incurred for the keeping of corporate minutes and the filing of various annual corporate reports to both federal and state agencies. Also, the practice must be operated as a corporation and may be subject to penalty if this rule is not strictly adhered to by the incorporator(s).
- 2. Accumulated Funds Problems:** Withdrawing funds from an incorporated practice can present several problems. If funds are withdrawn as salaries, the unreasonableness of salary might expose the practice to a serious problem with IRS. If cash is not withdrawn as salary and left to accumulate within the corporation, it may be penalized at the rate of 27½% on these accumulated funds in excess of \$100,000.
- 3. Other Disadvantages:** There are many other negative factors a physician should consider in deciding upon whether or not to incorporate. He should consider such problems as the exposure to the vulnerability of personal holding company status, on which income the IRS levies a penalty tax of 70%, and, the additional payroll tax cost for both social security, and federal and state unemployment tax which he will never collect.

### Conclusion

There is no one answer to the question of incorporation on the part of physicians. The answer depends on the particular circumstances of each physician. Yet as a tentative answer, under the present tax laws, the advantages of incorporation would seem to outweigh the disadvantages, especially for those whose gross income is in excess of \$100,000. ▲

# *Doctor's News*

**ISMS HOSTING UNIQUE LEGISLATIVE SEMINAR**—ISMS is hosting a unique Legislative Seminar September 20-22, 1974, at the Chateau Louise, Dundee. The seminar will bring together Illinois physicians, and spouses, to meet informally with state legislators and leaders. The purpose of the seminar is to afford participants the opportunity to become acquainted with key legislators and to gain a better understanding of the process of government.

For details, contact the Public Affairs Committee, ISMS, 360 N. Michigan Ave., Chicago 60601; phone 312-782-1654.

**PL93-282 ALCOHOLISM ACT IN EFFECT**—The "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act (Amendments of 1974)" is in effect, and hospital administrators should be urged to review PL93-282 to ensure compliance with the Act.

Under PL93-282, all federal funds, including Medicare, Medicaid, etc., will be discontinued to hospitals that refuse to treat patients with the disease of alcoholism; and all records of patients treated for alcoholism must be kept in strict confidence.

To obtain a copy of PL93-282, contact your IDMH Regional Alcoholism Coordinator office.

**DRUG AND ALCOHOL CONFERENCE PLANNED**—The Illinois State Medical Society, with the cooperation of the McLean County Medical Society, will sponsor a two-day workshop/conference on drug and alcohol dependencies. The programs are designed for medical, paramedical and school personnel; law enforcers and community workers.

The first session begins at 6:00 p.m., October 4, 1974, at the Ramada Inn, Bloomington and will feature a problem oriented discussion. The second session, Saturday, October 5, 1974, 9:00-4:00 p.m., Union, Illinois State University at Normal, will emphasize identification of scope of problem with workshop sessions on resource identification and therapeutic communities.

For further information, contact the ISMS headquarters, 360 N. Michigan Ave., Chicago, 60601; phone 312-782-1654.

**PUBLIC AID ISSUES NEW CARDS**—August 1, 1974, the Illinois Department of Public Aid replaced the familiar "green card" used by Medicaid patients with a card in lighter green color. The purpose of the change is to distinguish public aid recipients from food stamp recipients. Physicians are advised not to rely solely on the green card for identification purposes, but should request additional identification.

**ILLINOIS FOUNDATIONS RECEIVE PSRO GRANTS**—The Chicago Foundation for Medical Care and the Quad River Foundation for Medical Care (Will, Grundy, Kankakee and Kendall counties) have received contracts for development of formal plans necessary to qualify as a conditionally designated PSRO. CFMC received \$225,760 and QRFC received \$46,135.

## PHYSICIANS IN THE NEWS—Lowell R. King, M.D., has been named Surgeon-in-Chief at The Children's Memorial Hospital, Chicago.

The Health and Hospitals Governing Commission of Cook County recently appointed Frank J. Jirka, Jr., M.D., River Forest, as Medical Director and Chief of Staff at Oak Forest Hospital, Oak Forest, the world's largest hospital for long-term care. The newly elected Trustee to the American Medical Association and Past President of the Illinois State Medical Society, Dr. Jirka serves on the President's Committee on Employment of the Handicapped.

David R. Boyd, M.D., Chief of the Illinois Trauma Network, has been named Director of the National Emergency Director of the National Emergency Medical Services, HEW.

F. E. Hirsch, M.D., Chicago and Elizabeth E. Koppenall, M.D., Elmhurst are new members of the ISMS Fifty Year Club.

David F. Fretzin, M.D., Northbrook, and Leon Prinz, M.D., Lincolnwood, have been elected President and Secretary-Treasurer, respectively of the Alumni Association of Michael Reese Medical Center.

Milorad Cupic, M.D., Olympic Fields, is a new Fellow of the American College of Anesthesiologists.

Marshall Falk, M.D., is the new Dean at Chicago Medical School.

Condolence is extended by the ISMS Offices, Trustees and Staff to the Dr. James A. McDonald Family in the passing of Mrs. McDonald. Dr. McDonald, Geneva, is the Vice Speaker of the ISMS House of Delegates.

Get Well Wishes are sent to Edward Piszczeck, ISMS Past President, who recently underwent surgery.

**ISMS CO-SPONSORING "TAP INSTITUTE"**—A "Trustee-Administrator-Physician (TAP) Institute" will be held October 4-5, 1974, O'Hare Regency Hyatt House, Chicago. This institute, co-sponsored by the Illinois State Medical Society and the Illinois Hospital Association, is designed to help participants develop and implement effective internal program to assure the quality of care within the hospital. For further information, contact Gaylen Newmark, IHA, 840 N. Lake Shore Drive; phone 312-664-9500.

### Dr. Greenhill Receives Achievement Award



J. P. Greenhill, M.D., Chicago, recently received the Outstanding Achievement Award from the Michael Reese Department of Obstetrics and Gynecology. Dr. Greenhill, author of a best seller for expectant mothers The Miracle of Life, was cited for his contributions to the fields of teaching, education and patient care. He has authored hundreds of papers in American and foreign journals. For over 50 years, Dr. Greenhill has been the Editor of the Yearbook of Obstetrics and Gynecology.

### New ISMS Field Service Representative



Jim Kopriva recently joined the ISMS staff as Field Service Representative. He is a graduate of the University of Illinois where he received his BA in finance.

As Field Service Representative, Mr. Kopriva assists the county medical societies, notably those without executive directors, in establishing programs; serves as an ISMS representative at county medical society and hospital staff meetings; further coordinates between programs of the state and county societies; and works with the membership when any problems may arise at the county level.

County societies that need assistance in any way should contact Mr. Kopriva at the ISMS headquarters, 360 N. Michigan Ave., Chicago, 60601; phone, 312-782-1654.



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# Personnel Development For The Illinois Emergency Medical Services System

BY R. R. HANNAS, JR., M.D./EVANSTON

The operation of the Illinois Emergency Medical Services System is based on the expanded roles of medical and allied health personnel, allowing them to function effectively in as many situations as possible. The accompanying article discusses the program itself. This article reviews the personnel being trained to implement the program.

There are five types of personnel being trained and utilized in emergency care program around the state:

## *Emergency Medical Technician-Ambulance (EMT-A)*

The EMT-A may have originally been an ambulance driver or attendant, a fireman, a policeman, or a private citizen who has volunteered to help his community. He or she is trained to be the link between the physician and the emergency patient in the field, to assess medical problems and communicate these to the medical personnel manning the emergency room. The EMT-A provides treatment as directed, and proceeds with the safe transport of the patient.

To be accredited, the EMT-A must have completed an 82-hour course, or its equivalent, and passed an examination given by the National Registry of Emergency Medical Technicians.

There are approximately 43 training programs situated in community colleges and hospitals throughout the state. Instructors for the courses include physicians, nurses, administrative, and legal personnel, usually affiliated with a Trauma Center. To date, Illinois has trained about 6,000 EMT-As, the most in the nation.

## *Emergency Medical Technician-Ambulance Advanced (Also referred to as EMT-A II or Paramedic)*

This person, already certified as an EMT-A, now takes additional courses to learn pathophysiological changes and their correction, rather than just symptom treatment.

R. R. HANNAS, JR., M.D., Vice Chairman for the Illinois State Medical Society Committee on Emergency and Disaster Care currently is the President of the American College of Emergency Physicians and Director of Emergency Services at Evanston Hospital, Evanston.

This person is prepared to man a mobile intensive care unit, to utilize telemetry equipment, and be expert in all life-saving procedures.

The Illinois Department of Public Health is the sole accrediting agency for this level, and has certified 234 such persons. The training is available in 11 Trauma Centers throughout the state. *Trauma Nurse—(Also referred to as an EMS Nurse or Critical Care Specialist)*

The Trauma Nurse is a specialist who has been given 4-5 weeks intensive training in the actual care and clinical evaluation of the critically injured patient. Special programs are available for RNs at eight Trauma Centers. The state has trained 358 Trauma Nurses, and eight Burn Nurse Specialists. Several additional specialty courses have been developed to meet the educational needs in the other major categories of emergent disease and include a 2-week Burn Nurse Specialty Course, 3-week Coronary Care Workshop, 2-week Acute Renal Care Course, and 3-week Perinatal Course.

## *Emergency Room Residencies*

Four hospitals, Billings and Northwestern in Chicago, St. Francis, Peoria, and Evanston Hospital, are presently offering residencies for emergency department physicians. This is a two year training program following a year of internship with guidelines established by the American College of Emergency Physicians.

## *Trauma Coordinators*

The Trauma Coordinator (TC) is usually an experienced, usually ex-military trained, administrator. His training is in the care and transportation of the critically injured. The TC is under the supervision of the staff physician. He coordinates the various components of the EMS system in his area, teaches, and handles public relations tasks. Each Trauma Center has a Trauma Coordinator.

County medical societies should become involved in any program which trains medical or allied health personnel. These programs need physician input as advisors, instructors, and evaluators.

*(Continued on page 132)*

# Illinois Emergency Medical Service System\*

## Status Report III (July, 1974)

BY WINIFRED ANN PIZZANO, B.A., TERESA L. ROMANO, B.S.N.,  
JOHN C. NANCE, HMC USN (FLT RES), AND DAVID R. BOYD, M.D.C.M.

On July 1, 1971, the State of Illinois embarked upon a statewide program to improve the delivery of emergency medical services with the initiation of the Trauma Program.<sup>1,2</sup> The progress to date and the projected future of the Illinois Statewide EMS Program are the subject of this report.

The Illinois Trauma-EMS Program became operational with the designation of some 50 general hospitals as Trauma Centers to improve the care of the critically injured patient. Strategically located throughout the state, these centers have been specially staffed and equipped to handle the complex needs of the critically injured patient with resuscitation, initial, and definitive care being provided by a process of successive triage of individual patients from the scene of an accident through the trauma hospital network of Local, Areawide, Regional, and "Special" Regional Centers. The most specific critical care necessary for all injured patients can be provided as clinical problems are identified and designated hospitals, specialty care units (e.g., spinal cord, burn, etc.) and transportation care resources are mobilized.<sup>10</sup> The trauma center approach has provided a stimulus for the development of subsystem implementation (communications, transportation, training, etc.) on a sound areawide, regional, and statewide basis. This trauma center systems approach has spread to several neighboring states (St. Louis, Mo.; Dubuque, Ia.; and

Evansville, Ind.) with these communities designating a Trauma Center Referral Hospital for appropriate services.

Initial funding for this program was from the National Highway Traffic Safety Administration (NHTSA) and provided the basic components for a network of interlocking trauma care centers. The lead agency in the State Health Department, the Division of Emergency Medical Services and Highway Safety (EMS-HS), was given the responsibility for the development of this program. In July, 1972, the Division of EMS-HS was awarded a four million dollar demonstration contract by the Department of Health, Education, and Welfare to expand the trauma care system to all categories of emergent disease (acute cardiac, high-risk infant, poisoning, alcohol and drug overdose, and psychiatric emergencies). The State of Illinois is now completing an echelon program of regionalized emergency health care delivery for all types of emergency medical care by emphasizing the critical treatment aspects of certain well-identified clinical groups.<sup>11</sup>

The essential emergency medical services subsystems of hospital categorization, communications, transportation, training and education of EMS personnel, public education, and evaluation are being further developed along regional lines and integrated into a total system for the delivery of emergency medical services for all categories of patients. All EMS programmatic efforts integrate these essential subsystems and are stylized to meet regional and local needs and objectives by utilizing and upgrading existing emergency care resources.

The regional program thrust of the Illinois statewide EMS effort has been to identify existing resources in all hospital facilities and their surrounding communities through a process of hospital emergency department categorization and areawide planning. After the initial designation of some 50 trauma and "special" trauma centers in the rural and metropolitan parts of the state, a statewide categorization of all hospitals for comprehensive emergency medical care has been

WINIFRED A. PIZZANO, B.A., is Assistant to the Division Chief, Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health. TERESA L. ROMANO, B.S.N., Operations Director for the Division of Emergency Medical Services and Highway Safety, IDPH. JOHN C. NANCE, HMC, USN (FLT RES) Field Operations Director of the Division of Emergency Medical Services and Highway Safety, IDPH. DAVID R. BOYD, M.D.C.M., is Chief of the Division of Emergency Medical Services and Highway Safety, IDPH, and Assistant Professor of Surgery, The Abraham Lincoln School of Medicine of the University of Illinois College of Medicine.

\*Supported in part by National Institutes of Health Grant NIH GM 18003-01, National Highway Traffic Safety Work Project (NHTSA), and Department of Health, Education, and Welfare Demonstration Contract HSM 110-72-345.

accomplished and is presently undergoing a second annual review and progressive planning phase.<sup>4</sup>

Ambulance services providers and their respective communities across Illinois have accepted the national criteria for equipment and training of ambulance personnel.<sup>13</sup> Ambulance standards legislation, which incorporates federal standards, has been reintroduced to the Illinois legislature. The "Paramedic" law (PA 76-2295) has been amended to a permanent statutory responsibility of the Division of EMS-HS.

### **Emergency Medical Transportation**

#### *Primary Response System*

During the past year, the emergency transportation subsystem has become more clearly defined and developed at both the state and local levels. The "Ambulance Strategy for Illinois"<sup>15</sup> described a plan for the development of a complete statewide primary ambulance coverage utilizing existing medical resources and is being used as a guideline by the Illinois Department of Transportation (IDOT) in awarding of grants for ambulances and medical equipment. Over the past two years, 90 nationally recommended design<sup>13</sup> ambulances have been funded and placed. It is projected that an additional 90 ambulances will be placed in the coming year following the statewide placement strategy.

To encourage more effective evaluation and planning of local emergency transportation systems, the Division of EMS-HS has developed a set of reporting forms which include an Ambulance Dispatch Record Form, an Ambulance Call Report Form, an Emergency Room Encounter Form, a Transfer Form, and a Mobile Intensive Care Unit Form. Through the use of these forms, patient transportation care can be more effectively documented and evaluated.

#### *Secondary Response System*

Over the past two and one-half years, more than 400 patients, transplant organs and donors have been transferred under emergency conditions by helicopter. Air medical transport resources for Illinois now include helicopters of the Illinois Department of Transportation (IDOT), Chicago Fire Department, Army National Guard, Coast Guard, and a Kentucky-based Army Military Assistance to Traffic and Safety (MAST) unit. Fixed-wing aircraft operated by civilians, Southern Illinois University, IDOT, and the Chicago Fire Department have also provided substantial assistance. With the recent purchase of

an additional Bell 206A helicopter, the IDOT now provides statewide 24-hour aeromedical coverage.

Overland Critical Care Vans (OCCV's)<sup>3</sup> will be stationed in six regional communities and provide service to their surrounding regions later this year. These special intensive care transportation units will provide sophisticated medical care for all types of critically ill or injured patients during transfer to advanced specialty treatment centers (e.g., burn, high-risk infants, etc.)

### **Emergency Medical Services Planning**

The development of the Trauma-EMS and the Comprehensive Health Planning Agency (CHP "A" and "B") programs were initiated simultaneously in Illinois. The development of areawide EMS plans (e.g., categorization of hospital capability for emergency medical services, communications design, and ambulance placement) has been integrated with the local CHP "B" planning activity whenever possible and feasible. Areawide EMS planning and implementation of operational programs have evolved concomitantly and have developed a considerable measure of sophistication and effectiveness. At the present time, all EMS activities are being generated at the local level through the area EMS committee/council structure and reviewed by the Comprehensive Health Planning Agency.<sup>4</sup> The CHP "B" Agency is responsible for providing the review and comment mechanism. This usually consists of an EMS provider-dominated council that integrates the planning efforts of the various subsystems committees.

In Illinois, the hospital areawide EMS committee is responsible for initiating the planning process by describing the area emergency care capability and special care potential of each member hospital. This initial identification of areawide EMS care capability and triage patterns allows the development of projects for the subsystems of transportation, communications, training, public education, and program evaluation.

Hospital categorization and areawide planning (40 area plans) have made possible the extension of life-saving care from the metropolitan centers to the rural parts of Illinois. This program has resulted in increased hospital physician coverage even in the most rural areas of the state where at least one hospital in each EMS areawide plan now provides a 24-hour physician in-house to support the entire EMS area. Linkages between the rural hospitals to established regional specialty care centers have resulted in improved professional liaison and transportation care of pa-

tients with specific care problems not well served in the rural hospital. This reorientation of emergency clinical care capability on an areawide basis has provided the essential framework for the implementation of communications, transportation, training, evaluation, and EMS system management efforts.

### Communications

The MERCI network (Medical Emergency Communications of Illinois) provides hospital-to-hospital and ambulance-to-hospital communications to serve the Illinois EMS program.<sup>12</sup> Through the MERCI network, physicians can give medical direction to ambulance attendants at the scene and during transport. At completion there will be nine regional communications networks, each with its own radio control center (NCCC). The NCCC is equipped with a master radio console, which provides medical backup and remote control of ambulance radio channels and other hospital radios within the net. The network provides essential medical control for care advice and triage in day-to-day routine emergencies as well as area wide medical communications in natural disasters.

A MERCI manual has been printed and distributed to hospitals and ambulances.<sup>12</sup> There are 50 MERCI net hospital stations covering Illinois. To date, 690 radio-equipped ambulances operate in the MERCI system with six completed regional nets. Considerable experience has been gained with the operational benefits of this regional and disciplined radio-telephone medical control system. At the present time, the Division of EMS-HS is providing technical assistance to all areas to develop uniform citizen access numbers (911), multiagency central dispatch centers, and, where appropriate, radio telemetry for pre-hospital mobile intensive care.

### Public Education

Public education emanates from the development of areawide plans and program implementation at the local level. At the state level, the Division of EMS-HS offers technical assistance through the *Trauma Center Newsletter*, regional seminars, and by the distribution of materials to interested groups and to the media.

The *Trauma Center Newsletter* was first published in November, 1971, with 26 issues produced so far. These have described the many and varied facets of the Illinois Statewide Trauma-EMS Program, and have had as a primary objective the dissemination of information for improvement of trauma patient care.

### Education

Crucial to the success of a program to deliver emergency care is development of appropriate personnel and education of existing personnel. To this end, many activities are being undertaken. Training of ambulance attendants is offered, which are open for basic or advanced status, as well as annual refresher courses.

Nurse specialist education, stylized to the needs of particular areas, are offered throughout the state. Annual Symposia have been developed, with the next in September, in Chicago, for Trauma and Critical Care Nurses. Also, nurse training grants are given and a pilot 6-month Critical Care Nurse Residency will be offered in January, 1975.

Residencies in Trauma Medicine have been developed for physicians, utilizing curriculum guidelines of the American College of Emergency Physicians. Critical Care Fellowships have been awarded 14 medical professionals for studies in emergency medicine problems.

Trauma-EMS workshops for physicians are scheduled periodically across the state to gain input from all physicians. These set the stage for future development and planning in the overall statewide EMS program. All physicians are encouraged to participate.

### Evaluation

Several studies and data collection programs are ongoing, including the Trauma Registry and mortality statistics. During the coming year, management and program monitoring data will be collected through standard data forms and inventories. At the end of the contract period (July, 1975), a three-year evaluation, including management and impact data, will be published.

A highway death study reported in a recent *Journal of Trauma Symposium*<sup>17</sup> described the effectiveness of the program in central Illinois during the first year of operation. The special emphasis of this report was the effect of the changing character of trauma patient distribution for all vehicular-related deaths within this area of Region 3-A.

During the study period of this report, the central 14 counties in Region 3-A experienced an increase in auto accidents (27%) and an increase in persons sustaining injury (16%) and a decrease in the percentage of deaths (15%). Of particular significance was the steady decline in the percentage of deaths per person injured from 2.8% to 2.1% for the study period.

This same tendency has continued in this region throughout the second full year of pro-

gram operation. The initial study protocol reported above was subsequently expanded to include an 18-month preprogram and a 2-year operational period in the same 14-county area.<sup>11</sup> All highway-related accidents, injuries, and fatalities in this region were collected for the preprogram (control), implementation, and full operation periods from available Illinois death records, state police and Department of Transportation records, as well as the Trauma Registry.<sup>18</sup>

An overall comparison of the deaths, accidents, injuries, and death to injury ratio (%D/I) for preprogram and full operation periods has shown that while there was an increase in the number of accidents (+12%) and a slight decrease in injuries (-1.5%), there was a decrease in deaths (-10%) and the D/I ratio (-7%). Every comparable 6-month time period in this study (12 time period comparisons) showed improvements in the number of vehicular deaths and death to injury ratio, usually in spite of an increased incidence of auto accidents. The one exception to this overall tendency was the comparison of July to December 1971 and July to December 1972, where no change in death rate (0%) occurred. During this period, the number of accidents decreased (-5%) as did injuries (-13%), and the death to injury ratio increased (from 2.5% to 2.9%). Seasonal effects may have a significant influence on these data.

The most significant six-month period comparison so far observed is the preprogram period (January to June 1971) and a comparable full program period two years later (January to June 1973). This period comparison, two years apart, shows significant and remarkable changes. The comparisons of the January to June periods for the years 1971 to 1973 indicate a 29% decrease in vehicular accident deaths with a 17% increase in the number of accidents and a slight decrease (1%) in the number of related injuries, and a 28% decrease in the death to injury ratio (from 2.5% to 1.8%).

It appears that significant decreases in deaths from vehicular causes have occurred in Region 3-A over the first two-year period of the Illinois Trauma Program. This and other supporting data indicate that a significant impact may result from a "trauma center" approach due to a redirection of relatively small numbers of the most critically injured patients within a region to designated trauma center hospitals.

## Clinical Categories For Areawide EMS Planning

As a recommendation to the Illinois EMS Categorization Law (PA 76-1858), all areawide plans were asked to address themselves to six clinical categories of emergent disease: trauma, acute coronary, high-risk infant, poison control, drug overdose and alcohol detoxification, and psychiatric emergencies. Clinical programs in these areas are underway throughout the state developed by EMS councils, with technical assistance from the Division of EMS-HS.

### *Cardiac Program*

Since the passage of the "Paramedic Law" (PA 77-2295) in October, 1972, several mobile intensive care programs have been developed. Under this act, hospitals may, with the approval of the Illinois Department of Public Health, conduct pilot programs in mobile intensive care, including the training and supervision of mobile intensive care personnel, commonly known as paramedics, or EMT-Advanced. The paramedic has liability coverage by state law to provide advanced life-support including intubation, defibrillation, and intravenous medication when in telemetry and radio contact with a physician or nurse.

There are five operational paramedic programs in Cook County and five new programs anticipated for the downstate area. Four satellite hospital programs further complement the Chicago program with linkages to the five hospital base stations transmitting via dedicated telephone lines.

*Rural Cardiac Care.* Not every hospital can economically or clinically support the full-scale operation of an intensive coronary care unit. In addition to the initial expense of monitoring equipment, the continuing major cost of staffing a unit with an adequate number of specially trained nursing personnel makes the coronary care unit unfeasible in the rural community hospital. An alternative to this problem appears to be remote cardiac care monitoring or the Outlying Coronary Care Unit concept (OCCU).

The OCCU is a telephone telemetry system utilizing leased telephone lines. The patient's electrocardiogram is continuously monitored at the outlying rural hospital (remote monitoring unit or RMU) and is transmitted via telephone lines to the receiving center in a larger community hospital (central monitoring unit or CMU). At the CMU, experienced coronary care nurses monitor the EKG signals of patients in the remote hospitals around the clock, along

with their own in-hospital patients.

The development of OCCU's is an essential cardiac component of the total EMS system in Illinois. The presence of large university or community hospitals surrounded by smaller, more rural hospitals, coupled with the recent strides made in areawide planning give Illinois a firm base on which to build this system. Moline Public Hospital, with its active and continually growing coronary care unit, has taken the OCCU initiative in Region 1-B.

Other hospitals have become interested in the OCCU concept and have seen its applicability to their respective areas. Springfield, Rockford, Champaign-Urbana, and Peoria all have submitted grant requests for the development of an OCCU project and are working closely with the Division of EMS-HS in this effort.

#### *Perinatal (High-Risk Infant) Program*

A program for the emergency care and transfer of neonates has been in existence in Illinois for the past 20 years. Under the Division of Family Health, Department of Public Health, the program included neonatal centers and a contractual transfer arrangement. A new, expanded program, coordinated with the existing emergency transportation system and established for the care of both the neonate and the high-risk mother, is presently undergoing review by the State Comprehensive Health Planning Agency. An updated network of perinatal facilities, including comprehensive and intermediate centers, will be established. The contractual transfer arrangements will be replaced by the emergency transportation system developed by the state EMS network with a choice of ambulance, helicopter, or Overland Critical Care Vans (OCCV's) described elsewhere in this report.

#### *Poison Control*

The 92 designated Poison Control Centers in the state are being incorporated into the areawide EMS plans. EMS councils are responsible for ongoing evaluation and upgrading of this clinical program.

#### *Alcohol, Drug Abuse, and Psychiatric Emergencies*

The Departments of Mental Health and Public Health will this year introduce a plan to areawide EMS committees for improved care of emergency alcohol problems. This will include the identification of hospitals capable of providing this care, firm referral patterns to rehabilitation and treatment centers, and public and

professional education in acute alcoholism.

Drug abuse and psychiatric emergencies will also be incorporated into the EMS system by the EMS councils. With this joint planning effort, better organized emergency care for these previously neglected patients will be realized.

### **EMS Councils**

Twenty-three Emergency Medical Services Councils have been established in Illinois to coordinate EMS planning and encourage more effective utilization of medical emergency resources at the local level. These councils act as adviser groups to the EMS providers, at the state and local levels.

Each council has committees identified to coordinate hospital categorization and areawide hospital emergency services. The public education committee chairmen have been selected and seminars have been held to discuss methods of increasing public awareness of the EMS system and to assist in the implementation of public access mechanisms (e.g., "911"). The communication and transportation committees usually have duplicate membership as they consider common problems, such as the need for central dispatch of ambulances, the passage of local ordinances regulating ambulance services, and the coordination of ambulance services and communications resources. The committees on training have evaluated the needs of the professional and para-professional emergency medical personnel and have encouraged the development of interhospital educational programs and special interest courses. The EMS councils are presently addressing the problems of program evaluation starting with EMS resources inventories and EMS process measures utilizing the emergency report forms. Output studies with Trauma Registry<sup>19</sup> data are ongoing and will be further developed statewide.

Major emphasis of the EMS councils, during the past year, has been on the initial organization and establishment of committees and the formulation of local program objectives. With this basic organizational process near completion, program implementation will be continued on an even more active level during the coming year.

### **Summary**

By defining the problems of the critically injured patient, and by categorizing hospital emergency capabilities for specific patient groups, significant EMS progress has already been real-

*(Continued on page 132)*

# Editorials



## Anger

The late N. C. Gilbert said on many occasions that every emotion, except pity, could trigger a heart attack. How true. Anger is, perhaps, the most lethal of human emotions. This was best popularized by John Hunter who said that his "life was in the hands of any rascal who chose to annoy and tease him". And there can be no doubt that his death was hastened by the violent disagreements he had with his colleagues at St. George's Hospital. He died on October 16, 1793 following a board of governors meeting of St. George's Hospital at which a colleague made him the brunt of some disparaging remarks.

Anger can be an individual or a family affair, or a racial, national, or international trait. As an intense emotion, it most certainly overstimulates the brain and the harm comes when there is no way to let off steam. Having one's say is, perhaps, the best remedy, but this is not always possible. Besides, we have already experienced the period of anger. Fighting anger with anger, however, is better than pent-up hostility because stewing about a problem is not the answer.

I believe that anger is as serious a risk factor as are cholesterol, hypertension, and cigarette smoking. Nowadays, anger is difficult to avoid considering our social and political environment. Physicians also have their share of complaints about the direction in which the practice of medicine is going. It is not easy to remain calm when buried under tons of paper work, third parties, PSRO, government rules and regula-

tions, the use of generic vs. trade names, and the only too real threats of malpractice suits.

Things are not as they were 10, or even five, years ago. And the rules of the game are not always honest. But knowing the bad effects of anger gives the physician a head start on preventing the consequences. Professional men should be above petty jealousies and it is here that the old adage "only dogs get mad" is apropos.

The risks that follow outbursts of anger can be minimized by controlling one's temper. One way is to avoid anonymity because humans do many silly things when they think no one knows them. Every day when driving the car or eating in a restaurant we see examples of this. Dr. William B. McGrath suggests that we have our names painted prominently on the trunk or sides of our cars.

Cultivating an interest in others also tends to lessen anger. In pioneer days, there were many ways in which a person could help his neighbor. The desire to be helpful is still there. Compassion and kindness beyond the line of duty brings us back to Dr. Gilbert's observation. If we can't avoid anger, we can at least take pity on others so that each of us will benefit. Anyone who gives it a little thought will agree that with all of our other problems, we certainly do not need a dog-eat-dog world.

T. R. Van Dellen, M.D.  
*Editor*

## **Model Cities Alcoholism Program Receives National Grant Award**

Model Cities-CCUO's Alcoholism Recovery and Rehabilitation Program has been awarded an additional year of support commencing Sept. 1, 1974, by the National Institute on Alcohol Abuse and Alcoholism of the U.S. Dept. of Health, Education, and Welfare, as recently reported by Erwin A. France, Administrative Assistant to Mayor Daley and Director of Model Cities-Chicago Committee on Urban Opportunity.

"This action was based on the Institute's consideration of the Model Cities-CCUO Alcoholism Program's past accomplishments and continuing progress in meeting goals and objectives," said John C. Wolfe, Ph.D., Director of the Division of Special Treatment and Rehabilitation Programs.

Model Cities-CCUO's free Alcoholism Program is well on its way toward becoming the most ef-

fective in the city in treating the alcoholic and his family, according to results seen among 1,000 participants—the alcoholics and their families—who are currently being served by the alcoholism programs conducted by 11 of Model Cities-CCUO's Urban Progress Centers.

Urban Progress Centers offering the Alcoholism Program are located at 901 W. Montrose Ave., 2550 W. North Ave., 1445 N. Clybourn Ave., 3952 W. Jackson Blvd., 3138 W. Roosevelt Rd., 10 S. Kedzie Ave., 1935 S. Halsted St., 4622 S. King Dr., 1030 E. 63rd St., 839 W. 64th St., and 9231 S. Houston Ave.

For further information or assistance, please call on our office, (312) 744-3960.

Mrs. Erma Turner, *Director*,  
Model Cities CCUO's Alcoholism Program  
640 N. LaSalle St., Chicago 60610

## **Banning the Trampoline in Our Schools**

This is an idea whose time has come: physicians should take the lead in advocating the complete ban on the use of the trampoline in our schools. Physicians have all but conquered paralytic polio in the United States through mass immunization. But what is the point of immunizing against one crippler, while allowing our children to become injured or even quadriplegic as the result of trampoline accidents?

Dr. Walter Stolov, a specialist in rehabilitation medicine at the School of Medicine of the University of Washington advocates the complete ban on the use of the trampoline in the physical education program of all elementary, junior and senior high schools and colleges. The school principals of the largest county in the state of Washington have, in fact, banned the trampoline from their sports programs. Dr. Stolov has seen seven cases of quadriplegia following trampoline accidents in 13 years of practice. In each case, the injury occurred while the student was engaged in trampoline activities as part of an organized sports program. Most of the quadriplegias occurred as a result of acute cervical flexion while improperly executing a back flip or a somersault.

Each year about 11,000 persons of all ages in the United States sustain spinal cord injuries. We

do not know exactly how many result from trampoline injuries.

The Accident Prevention Committee of the American Academy of Pediatrics has gone on record in support of Dr. Stolov's stand that the trampoline be completely banned as an organized school sport. The chairman of this committee, Dr. Robert G. Scherz has stated: "Very little is lost if the trampoline is removed as a sports activity. Students interested in body control athletics can achieve it through the diving board, routine gymnastics and the high jump. Spotters around the trampoline cannot prevent this catastrophic injury from developing because it does not occur as a result of falling off the trampoline. The injury occurs in the center of the trampoline where no one can prevent it."

What can doctors in our state do about it? First, look into the athletic programs of the schools in your community and determine if the trampoline is used as an activity. Secondly, find out if quadriplegias or other serious neurologic injuries have occurred as a result of trampoline activity. Thirdly, urge the school board or the athletic director of the school to ban the use of trampolines in their school. □

Harvey Kravitz, M.D.

## **Emergency Medical Personnel Development . . .**

(Continued from page 124)

Hospitals participating in an area's EMS plan or part of a system may divide up training responsibilities. One hospital may provide the EMT-A training and another may take the EMT-A II training. Trainees should have their clinical hours in the emergency departments to which they will be bringing most of their patients.

Team work is most important, and all personnel in a system must know each other and work together.

If you believe that your community or hospital should offer a program for the development of emergency personnel, contact the Division of Health Care Delivery, ISMS Office, 360 N. Michigan, Chicago, or call 312-782-1654, for information. ◀

*Ed. Note:* A complete listing of trauma centers in Illinois and EMT-A EMT-A II, and Trauma Nurse training locations will be published in the annual Reference Issue, October, 1974, issue of the *Illinois Medical Journal*.

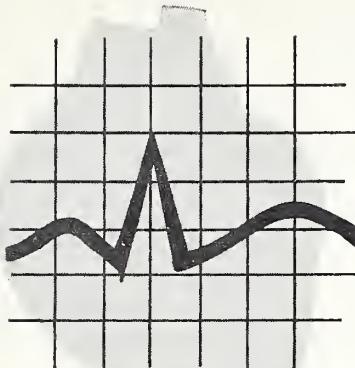
# Illinois Emergency Medical Service Status Report III

(Continued from page 129)

ized in Illinois. The Illinois EMS program was facilitated by a statewide experience gained in the trauma categorization model. The trauma program has stimulated sound areawide EMS planning based on self-categorization of all participating hospital and by incorporating plans to account for area EMS deficiencies and strengths. Each area plan has attempted to initiate a "systems approach" to the six identified major clinical patient groups as outlined above. Subsystems development, equipment purchases and other financial allocations were made to support real clinical problems as identified in the local and regional EMS plans. The Illinois EMS program has demonstrated the roles of state and local planning and operations necessary in order to establish effective local, regional, and statewide emergency medical care delivery programs.

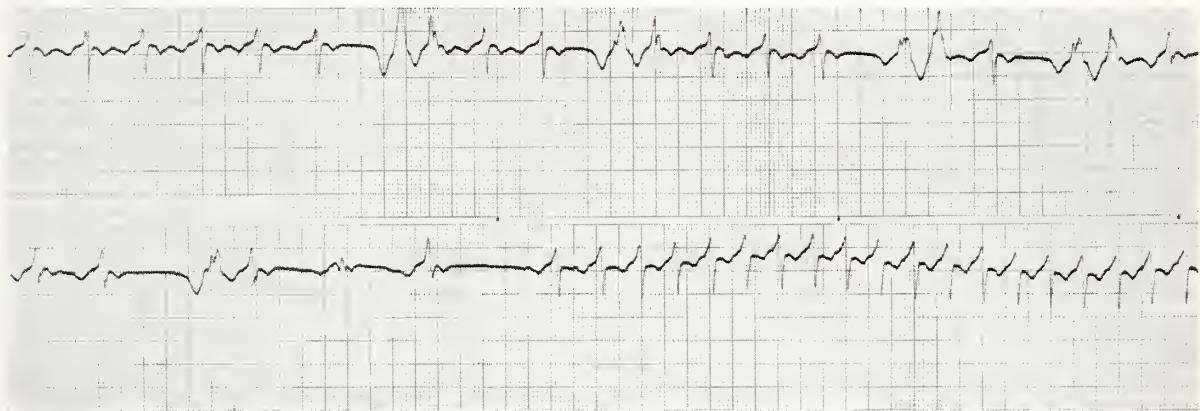
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A complete bibliography may be obtained by writing the *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago, 60601.



## ekg of the month

JOHN R. TOBIN, M.D., M.S., RIMGAUDAS, NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
JAMES V. TALANO, M.D., SARAH JOHNSON, M.D. and  
ROLF M. GUNNAR, M.D., M.S./Section of Cardiology,  
Loyola University Stritch School of Medicine



A 44-year-old female with no prior history of heart disease presents to the emergency room with palpitations. She states the palpitations started abruptly some four hours ago and have made her lightheaded. Her blood pressure is 80/40 mmHg, and she looks pale but alert. The ECG is monitored and right sided carotid sinus massage is initiated. The continuous ECG rhythm strip was recorded.

### Questions:

**1. The ECG rhythm strip shows:**

- A. Acute myocardial infarction.
- B. Ventricular tachycardia.
- C. Supraventricular tachycardia.
- D. Escape idioventricular beats and pairs of premature ventricular beats.
- E. All of the above.

**2. The following statements are true:**

- A. Carotid sinus massage is dangerous.
- B. The pairs of premature ventricular beats might require lidocaine intravenously.
- C. The arrhythmias here are definite evidence for myocardial infarction.
- D. Watchful expectation and ECG monitoring should be performed.
- E. All of the above.

(Answers on page 136)

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
360 No. Michigan Ave. • Chicago, IL 60601 • (312) 782-1654



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events.

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## SEPTEMBER

### Alcoholism

#### ALCOHOLISM

For: All Physicians, Allied Health. Weekly medical education seminar, Sept. 24, 1974, 11:30 AM, Memorial Hospital of DuPage County, Elmhurst, Ill. Speaker: Herbert Neuhaus, M.D., Dept. of Public Health Hosp., Chicago. Hrs. of Instr.: 1. **CME Credit:** AMA Category 1. Sponsor, contact: John H. Huss, M.D., DME, Memorial Hospital of DuPage County, Avon Rd. & Schiller St., Elmhurst, IL 60126.

### Cardiology

#### ARRHYTHMIAS AND ANESTHESIA

For: All physicians, nurses. Lecture, Sept. 11, 1974, Martha Washington Hospital, Chicago. **CME Credit:** 1 hr. AMA Category 1. AAFP. Sponsor, contact: F. Lopez-Fernandez, M.D., Med. Dir., Martha Washington Hospital, 4055 N. Western Ave., Chicago 60618; (312) 583-9000, ext. 331.

#### CARDIOVASCULAR DISEASES

For: All physicians. Lecture, group discussion, Sept. 13, 10 AM, S.R. Forkosh Hospital; Sept. 13, 6 PM, Lincolnwood Hyatt House; Sept. 14, 10 AM, Bethany Methodist Hospital. Speaker: G. T. Gau, M.D., Mayo Clinic. **CME Credit:** 5 hrs. AMA Category 1. Fee: \$10 (non-staff, for dinner). Reg. Deadline: Sept. 9, 1974. Sponsor: FAB®-CME. Contact: Mr. S. Plotner, S. R. Forkosh Hospital, 2544 W. Montrose, Chicago, IL 60618; (312) 267-2200.

#### INTERNATIONAL SYMPOSIUM ON EPIDEMIOLOGY OF HYPERTENSION

For: All Physicians, Epidemiologists. 3-day symposium, Sept. 18-20, 1974, Sheraton-Blackstone Hotel, Chicago. Fee: \$150 (\$75 students). Sponsor, contact: Helen Heck, Chicago Heart Association, 22 W. Madison St., Chicago, IL 60602.

#### INTERMEDIATE CARDIOLOGY

For: All Physicians. 4½ day course, Sept. 23-27, 1974, Chicago. Hrs. of Instr.: 32 approx. **CME Credit:** AMA Category 1. Fee: \$175. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

### Emergency Care

#### EMERGENCY ROOM MEDICINE

For: Internists, Emergency Physicians, Sept. 16-18, 1974, Arlington Park Towers Hotel, Arlington Hts., Ill. **CME Credit:** 22 hrs. AMA Category 1. Fee: \$100 mbrs.; \$150 non-mbrs. Reg. Limit: 300. Sponsor, contact: Registrar, Postgrad. Courses, Amer. Coll. of Physicians, 4200 Pine St., Philadelphia, PA 19104. Co-sponsors: Amer. Coll. of Surgeons, Loyola Univ. Stritch Sch. of Med.

### General Interest

**MEDICAL-LEGAL ASPECTS IN PRACTICE OF MEDICINE**  
For: All physicians, nurses. Lecture, Sept. 4, 1974, Martha Washington Hospital, Chicago. **CME Credit:** 1 hr. AMA Category 1, AAFP. Sponsor, contact: F. Lopez-Fernandez, M.D., Med. Dir., Martha Washington Hospital, 4055 N. Western Ave., Chicago 60618; (312) 583-9000, ext. 331.

### Internal Medicine

#### REVIEW COURSE IN RHEUMATOLOGY

For: Family Physicians. 1-week course, Sept. 9-13, 1974, Chicago. Hrs. of Instr.: 35 approx. **CME Credit:** AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

#### REVIEW COURSE IN PULMONARY

For: Family Physicians. 1-week course, Sept. 9-13, 1974, Chicago. Hrs. of Instr.: 35 approx. **CME Credit:** AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

#### RECENT CONCEPTS IN DIABETIC MANAGEMENT

For: All Physicians, Allied Health. Weekly medical education seminar, Sept. 10, 1974, 11:30 AM, Memorial Hospital of DuPage County, Elmhurst, Ill. Speaker: Ann M. Lawrence, M.D., Univ. of Chicago. Hrs. of Instr.: 1. **CME Credit:** AMA Category 1. Sponsor, contact: John H. Huss, M.D., DME, Memorial Hospital of DuPage County, Avon Rd. & Schiller St., Elmhurst, IL 60126.

#### REVIEW COURSE IN HEMATOLOGY

For: Family Physicians. 1-week course, Sept. 30-Oct. 4, 1974, Chicago. Hrs. of Instr.: 35 approx. **CME Credit:** AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

#### REVIEW COURSE IN INFECTIOUS DISEASES

For: Family Physicians. 1-week course, Sept. 30-Oct. 4, 1974, Chicago. Hrs. of Instr.: 35 approx. **CME Credit:** AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

#### REVIEW COURSE IN NEPHROLOGY

For: Family Physicians. 1-week course, Sept. 30-Oct. 4, 1974, Chicago. Hrs. of Instr.: 35 approx. **CME Credit:** AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

#### SPECIALTY REVIEW IN NEUROLOGY—CLINICAL

For: All Physicians. 1-week course, Sept. 9-13, 1974, Chicago. Hrs. of Instr.: 44 approx. **CME Credit:** AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

### Obstetrics/Gynecology

#### BASIC GYNECOLOGY

For: All Physicians. 1-week course, Sept. 16-20, 1974, Chicago. Hrs. of Instr.: 35 approx. **CME Credit:** AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

### Occupational Medicine

#### 34TH CONGRESS ON OCCUPATIONAL HEALTH

For: Industrial Physicians, Nurses, & Safety Engineers. Symposium-workshop, Sept. 9-10, 1974, Marriott Motor Hotel, Chicago. **CME Credit:** 12 hrs. AMA Category 1. Fee: \$20. Sponsor, contact: Henry F. Howe, M.D., AMA Dept. of Environmental, Public, & Occupational Health, 535 N. Dearborn St., Chicago, IL 60610. Co-sponsor: Nat'l. Institute for Occupational Safety & Health, U.S. Dept. of HEW.

### Pediatrics

#### COMPREHENSIVE CHILDHOOD TRAUMA SYMPOSIUM

For: All Physicians. 2-day symposium, Sept. 11-12, 1974, Stouffer's Inn, Indianapolis. Hrs. of Instr.: 14. **CME Credit:** AMA Category 1. Sponsor, contact: Dr. John Roscoe, Program Co-ord., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

### Plastic Surgery

#### REVIEW COURSE IN PLASTIC SURGERY

For: Plastic Surgeons. 3-day lecture series, Sept. 3-5, 1974, McGaw Med. Ctr., Northwestern Univ., Chicago. Hrs. of Instr.: 18½. Fee: \$200. Reg. Deadline: July 31, 1974. Sponsor: Dept. of Surgery, Northwestern Univ. Med. Sch. Contact: D. A. Kerahan, M.D., Childrens Memorial Hospital, 2300 Childrens Plaza, Chicago, IL 60614.

### Psychiatry

#### CURRENT & FUTURE PERSPECTIVES IN TREATMENT OF ALCOHOLISM

For: All Physicians. Lecture, Sept. 18, 1974, 7:30 PM, Forest Hosp. Professional Ctr., Des Plaines, Ill. Speaker: R. J. Catanzaro, M.D., The Palm Beach Institute, Florida. Fee: \$15 (\$5 students). Sponsor, contact: Forest Hospital, 555 Wilson Lane, Des Plaines, IL 60016; (312) 827-8811, ext. 362.

### Surgery

#### MANAGEMENT OF COMPLICATIONS IN SURGERY

For: All Physicians. 4-day course, Sept. 16-19, 1974, Chicago. Hrs. of Instr.: 28 approx. **CME Credit:** AMA Category 1. Fee: \$175. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

#### UPPER MIDWEST REVIEW OF GASTROENTEROLOGY

For: All Physicians. 1½-day lecture & discussion, Sept. 21-22, 1974, Pfister Hotel, Milwaukee. **CME Credit:** 10 hrs. AAFP. Fee: \$125. Sponsor, contact: The Medical College of Wisconsin, c/o A. T. Finnegan, Course Coord., 561 N. 15th St., Milwaukee, WI 53233.

#### FLUID & ELECTROLYTE MANAGEMENT

For: All Physicians. 1-week course, Sept. 23-27, 1974, Chicago. Hrs. of Instr.: 30 approx. **CME Credit:** AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

#### DISEASES OF ESOPHAGUS, STOMACH & DUODENUM

For: All Physicians. 3-day course, Sept. 26-28, 1974, Chicago. Hrs. of Instr.: 20 approx. **CME Credit:** AMA Category 1. Fee: \$125. Sponsor, contact: Cook County Grad. Sch. Med., 707 S. Wood St., Chicago 60612.

#### SPECIALTY REVIEW IN GEN. SURGERY—PART I

For: Surgeons. 2-week course, Sept. 30-Oct. 11, 1974, Chicago. Hrs. of Instr.: 94 approx. **CME Credit:** AMA Category 1. Fee: \$350. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

# OCTOBER

## Anesthesiology

### COURSE III—EKG FOR ANESTHESIOLOGISTS

For: Anesthesiologists. 1-week course, Oct. 28-Nov. 1, 1974, Chicago. **CME Credit:** 35 hrs. (approx.) AMA Category 1. Fee: \$200. Reg. Limit: 35. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

### ACUPUNCTURE ANESTHESIA

For: All physicians, allied health. Weekly seminar, Oct. 29, 1974, Memorial Hospital of DuPage Co., Elmhurst, Ill. Speaker: H. Havdala, M.D., Mt. Sinai Hosp. **CME Credit:** 1 hr. AMA Category 1. Sponsor, contact: J. H. Huss, M.D., Dir. Med. Educ., Mem. Hosp. of DuPage Co., Avon Rd. & Schiller St., Elmhurst, IL 60126; (312) 833-1400, ext. 556.

## Cancer

### TUMORS OF URINARY TRACT

For: All Physicians. Symposium, Oct. 16, 1974, Ruth Lake Country Club, Hinsdale, Ill. **CME Credit:** 3 hrs. AMA Category 1. Reg. Deadline: Oct. 14, 1974. Sponsor, contact: DuPage County Medical Soc., 646 Roosevelt Rd., Glen Ellyn, IL 60137.

## Cardiovascular

### REHABILITATION FOR RECENT ACUTE MYOCARDIAL INFARCTION

For: All physicians, nurses. Lecture, Oct. 25, 1974, Martha Washington Hosp., Chicago. **CME Credit:** 1 hr. AMA Category 1. Sponsor, contact: F. Lopez-Fernandez, M.D., Med. Dir., Martha Washington Hospital, 4055 N. Western Ave., Chicago, IL 60618.

### BASIC ELECTROCARDIOGRAPHY

For: Family Physicians. 1-week course, Oct. 28-Nov. 1, 1974, Chicago. **CME Credit:** 35 hrs. (approx.) AMA Category 1. Fee: \$200. Reg. Limit: 35. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

## Dermatology

### BASIC DERMATOLOGY

For: Family Physicians. 1-week course, Oct. 14-18, 1974, Chicago. **CME Credit:** 30 hrs. (approx.) AMA Category 1. Fee: \$175. Reg. Limit: 30. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

## Drug Dependencies

**CONFERENCE ON DRUG & ALCOHOL DEPENDENCIES**  
For: All physicians, allied health, school & community workers. Symposium & workshop, Oct. 5, 1974 (plus Oct. 4, for school personnel only), Student Union, Illinois State Univ., Normal, Ill. **CME Credit:** 6 hrs. AMA Category 2. Fee: \$5 (plus lunch). Reg. Deadline: Sept. 27, 1974. Sponsor, contact: Committee on Alcoholism & Drug Dep., Ill. State Med. Soc., 360 N. Michigan Ave., Chicago 60601; (312) 782-1654. Co-sponsors: McLean County Med. Soc.

## Endocrine-Metabolism

### THYROID DISEASE

For: Family Physicians, Internists, Pediatricians, Nuclear Medicine. 1½-day lecture/round table, Oct. 11-12, 1974, Pfister Hotel, Milwaukee, Wis. **CME Credit:** 10 hrs. AAFP. Fee: \$125. Reg. Limit: 100. Sponsor, contact: Medical Coll. of Wis., c/o A. T. Finnegan, Ofc. of Cont. Educ., 561 N. 15th St., Milwaukee, 53233.

### SODIUM & WATER METABOLISM

For: All physicians, allied health. Weekly seminar, Oct. 15, 1974, Memorial Hospital of DuPage Co., Elmhurst, Ill. Speaker: A. R. Lavender, M.D., Hines V.A. Hospital. **CME Credit:** 1 hr. AMA Category 1. Sponsor, contact: J. H. Huss, M.D., Dir. Med. Educ., Mem. Hosp. of DuPage Co., Avon Rd. & Schiller St., Elmhurst, IL 60126; (312) 833-1400, ext. 556.

## General Interest

**NEWER CONCEPTS OF THE CLINICAL PHARMACIST**  
For: All Physicians & Allied Health. Weekly seminar, Oct. 1, 1974, 11:30 AM, Memorial Hospital of DuPage Co., Elmhurst, Ill. **CME Credit:** 1 hr. AMA Category 1. Sponsor, contact: John H. Huss, M.D., DME, Memorial Hospital of DuPage Co., Avon Rd. & Schiller St., Elmhurst, IL 60126; (312) 833-1400.

**THE OTHER DOCTOR IN YOUR PRIVATE PRACTICE**  
For: All Physicians & Allied Health. Weekly seminar, Oct. 8, 1974, 11:30 AM, Memorial Hospital of DuPage Co., Elmhurst, Ill. **CME Credit:** 1 hr. AMA Category 1. Sponsor, contact: John H. Huss, M.D., DME, Memorial Hospital of DuPage Co., Avon Rd. & Schiller St., Elmhurst, IL 60126; (312) 833-1400.

## General Interest/CME Methods

### INTRODUCTION TO CME TECHNIQUE

For: Hospital and other CME program planners. Two identical workshops held simultaneously, Oct. 4-6, 1974, Marriott Inn, St. Louis and Oak Brook Hyatt House, Oak Brook, Ill. **CME Credit:** 14 hrs. AMA Category 1 (plus 4 hrs. extra on completion of post-workshop assignment). Fee: \$125. Reg. Limit: Deadline: 20 each; Sept. 20, 1974. Sponsor, contact: Illinois Council on Cont. Med. Educ., 360 N. Michigan Ave., Chicago, IL 60601.

## Nuclear Medicine

### ADVANCES IN DISEASE DETECTED BY NUCLEAR SCANNING

For: All physicians. Frontiers of Medicine lecture, Oct. 9, 1974, Billings Hosp., Chicago. **CME Credit:** 3 hrs. AMA Category 1, AAFP. Fee: \$15. Sponsor, contact: Frontiers of Med., Univ. of Chicago, Box 451, 950 E. 59th St., Chicago 60637.

## Obstetrics-Gynecology

### POSTGRAD COURSE IN OB-GYN

For: Ob/Gyn. Lecture, case presentation, discussion, Oct. 24-26, 1974, Ctr. for Cont. Educ., Univ. of Chicago, Chicago. **CME Credit:** 33 hrs. (approx.) AMA Category 1. Fee: \$225. Sponsor, contact: F. P. Zuspan, M.D., Chicago Lying In Hosp., Univ. of Chicago, 5841 S. Maryland Ave., Chicago, IL 60637.

### SPECIALTY REVIEW IN OB-GYN

For: Specialists. 2-week course, Oct. 28-Nov. 8, 1974, Chicago. **CME Credit:** 86 hrs. (approx.) AMA Category 1. Fee: \$350. Reg. Limit: 85. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

## Orthopaedics

### MANAGEMENT OF COMMON FRACTURES

For: Family Physicians. 1-week course, Oct. 28-Nov. 1, 1974, Chicago. **CME Credit:** 30 hrs. (approx.) AMA Category 1. Fee: \$200. Reg. Limit: 30. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

## Pediatrics

### MANAGEMENT OF PEDIATRIC HEART DISEASE

For: All Physicians. 3-day course, Oct. 30-Nov. 1, 1974, Chicago. **CME Credit:** 21 hrs. (approx.) AMA Category 1. Fee: \$100. Reg. Limit: 45. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

## Psychiatry

### PSYCHIATRY FOR THE MEDICAL PRACTITIONER

For: All Physicians. 4-day course, Oct. 7-10, 1974, Chicago. **CME Credit:** 24 hrs. (approx.) AMA Category 1. Fee: \$175. Reg. Limit: 80. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

### CURRENT & FUTURE PERSPECTIVES IN DRUG ABUSE

For: All Physicians. Lecture, Oct. 16, 1974, 7:30 PM, Forest Hospital Professional Ctr., Des Plaines, Ill. Speaker: P. G. Bourne, M.D., Special Action Ofc. for Drug Abuse Prevention, Washington, D.C. Fee: \$15 (\$5 students). Sponsor, contact: Forest Hospital, 555 Wilson Lane, Des Plaines, IL 60016; (312) 827-8811, ext. 362.

### PSYCHOPHARMACOLOGY

For: Family Physicians, Specialists. Seminar, Oct. 16, 1974, Indiana Univ. N.W. Campus, Merrillville, Ind. **CME Credit:** 6 hrs. AMA Category 1. Sponsor, contact: Mr. John Roscoe, Program Coord., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202

### PSYCHIATRY FOR THE ADOLESCENT

For: All Physicians. Lecture, group discussion, Oct. 23, 1974, 10 AM, Bethany Methodist Hosp.; Oct. 23, 6 PM, Lincolnwood Hyatt House; Oct. 24, 10 AM, Belmont Hosp. Speaker: Beverly Mead, M.D., Dept. of Psychiatry, Creighton Univ. Sch. of Med. **CME Credit:** 5 hrs. AMA Category 1. Fee: \$10 (non-staff, for dinner). Reg. Deadline: Oct. 18, 1974. Sponsor: FAB<sup>3</sup>-CME. Contact: Mr. D. Larson, Bethany Methodist Hosp., 5025 N. Paulina, Chicago, IL 60640; (312) 271-9040.

## Surgery

### PRE & POSTOPERATIVE CARE OF PATIENTS

For: Surgeons, Surgical Specialists. 4-day course, Oct. 29-Nov. 1, 1974, Chicago. **CME Credit:** 32 hrs. (approx.) AMA Category 1. Fee: \$175. Reg. Limit: 80. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

# NOVEMBER

## Alcoholism

### FIRST ANNUAL SYMPOSIUM ON ALCOHOLISM

For: All physicians. Nov. 13, 1974, 9:00-11:00 AM, Robt. C. Hartmann, Sr., Auditorium, Martha Washington Hosp., Chicago. **CME Credit:** 2 hrs. AMA Category 1, AAFP Elective. Reg. Limit: 110. Sponsor, contact: F. Lopez-Fernandez, M.D., Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chicago, IL 60618; (312) 583-9000, ext. 331.

## Dermatology

### CUTANEOUS MEDICINE

For: All physicians. Frontiers of Medicine lecture, Nov. 13, 1974, Billings Hospital, Chicago. **CME Credit:** 3 hrs. AMA Category 1, AAFP. Fee: \$15. Sponsor, contact: Frontiers of Med., Univ. of Chicago, Box 451, 950 E. 59th St., Chicago 60637.

## Family Medicine

### FAMILY PRACTICE REVIEW

For: Family Physicians. Nov. 4-8, 1974, Chicago. **CME Credit:** 40 hrs. (approx.) AMA Category 1. Fee: \$175. Reg. Limit: 50. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

## Internal Medicine

### BASIC INTERNAL MEDICINE

For: All physicians. Nov. 11-15, 1974, Chicago. **CME Credit:** 40 hrs. (approx.) AMA Category 1. Fee: \$175. Reg. Limit: 50. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

### ADVANCES IN MEDICINE

For: Specialists. Nov. 18-22, 1974, Chicago. **CME Credit:** 35 hrs. (approx.) AMA Category 1. Fee: \$175. Reg. Limit: 50. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

## Laryngology

### LARYNGOLOGY & BRONCHOESOPHAGOLOGY

For: All physicians. Symposium, Nov. 18-23, 1974, Chicago. Hrs. of Instr.: 42. Fee: \$300. Reg. Limit, Deadline: 20; Nov. 17, 1974. Sponsor, contact: Univ. of Ill. Abraham Lincoln Sch. of Med., 1855 W. Taylor St., Chicago, IL 60612.

## Neurology

### NEUROPHYSIOLOGICAL & CLINICAL ASPECTS OF ACUPUNCTURE

For: Physicians, Surgeons, Dentists. 3-day conference, Nov. 7-9, 1974, Hilton Hotel, Madison, Wis. **CME Credit:** AAFP Prescribed, AMA Category 1. Fee: \$90 (before Sept. 1); \$110 (after Sept. 1). Sponsor, contact: Dept. of Cont. Med. Educ., Univ. of Wis., 610 N. Walnut St., Madison, WI 53706.

## Obstetrics-Gynecology

### FEMALE CLIMACTERIC

For: All physicians, allied health. Weekly seminar, Nov. 19, 1974, Memorial Hospital of DuPage Co., Elmhurst, Ill. Speaker: A. Scammegna, M.D., Michael Reese Hosp. **CME Credit:** 1 hr. AMA Category 1. Sponsor, contact: J. H. Huss, M.D., Dir. Med. Educ., Mem. Hosp. of DuPage Co., Avon Rd. & Schiller St., Elmhurst, IL 60126; (312) 833-1400, ext. 556.

## Pediatrics

### GENERAL PEDIATRICS

For: All physicians. Nov. 18-22, 1974, Chicago. **CME Credit:** 35 hrs. (approx.) AMA Category 1. Fee: \$175. Reg. Limit: 30. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

## Psychiatry

### ON DEATH & THE CONTINUITY OF LIFE

For: All physicians. Lecture, discussion, Nov. 20, 1974, 7:30 PM, Forest Hosp. Professional Ctr., Des Plaines, Ill. Speaker: R. Lifton, M.D., Yale Univ. Fee: \$15 (\$5 students). Sponsor, contact: Forest Hosp., 555 Wilson Lane, Des Plaines, IL 60016.

## Surgery

### BLOOD VESSEL SURGERY

For: Specialists. Nov. 18-22, 1974, Chicago. **CME Credit:** 40 hrs. (approx.) AMA Category 1. Fee: \$300. Reg. Limit: 40. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

### SPECIALTY REVIEW, PART I

For: Specialists. Nov. 4-15, 1974, Chicago. **CME Credit:** 94 hrs. (approx.) AMA Category 1. Fee: \$350. Reg. Limit: 150. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

## Alcoholism—A General Hospital Meets the Challenge

(Continued from page 99)

which the patient was introduced at Little Company of Mary Hospital.

Goals and expectations of this program consist of a recovery rate which is acceptable for an effective alcoholism program. This general hospital program is not a short time treatment process, but must be looked upon as the entry point to long term treatment, either as an outpatient with A.A. involvement and professional counseling, or as an inpatient in one of the alcoholism rehabilitation centers.

### Summary

This care of alcoholism will conform to the standards of such care set by the Joint Commission on Accreditation of Hospitals. The two components of care which this, and any other general hospital can provide, are emergency care and after-care.

Some of the more elaborate psychosocial group therapeutics at Little Company of Mary Hospital would not be necessary for all general hospital programs. Local volunteer A.A. people from the community can provide much good counseling and many hospitals now have A.A. groups which meet in the hospital area. Ideally, every general hospital should take care of the acute alcoholism patient in the community, and establish an after-care system which would include an alcoholism rehabilitation center to which patients, who require more than a short inpatient experience, could be referred. A good rehabilitation center can serve a constellation of referring general hospitals. General hospitals would then be providers of acute care for which most of them have been designed.

This program for the general hospital care of acute alcoholism has served a large number of patients and is proving to be a feasible method of serving its community. The average daily census of acute alcoholism patients in this 550 bed hospital runs about 6 patients. This census figure remains generally low because of the short stay. The therapy sessions are also attended by those patients who are in the hospital for other conditions, but who suffer concomitantly from alcoholism, or whose alcoholism has been uncovered by a perceptive physician.

Finally, training opportunities are available for physicians and other professionals, so that all general hospitals, who seek to meet the challenge

of treating their community alcoholism patients, can attain this goal. ▶

### References

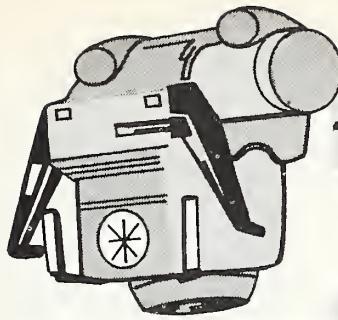
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West, James W., M.D., "New Program for Alcoholics—The Treatment of Alcoholism in a General Hospital," *Pacemaker*, Little Company of Mary Hospital, Vol. VI, No. 1, 1974.  
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### EKG of the Month

(Continued from page 133)

ANSWERS: 1. C.D 2. B,D. The ECG rhythm strip shows a supraventricular tachycardia at a rate of 215 beats per minute. Note that the last R-R cycles prior to cessation of the tachycardia lengthen noticeably. This is presumptive evidence that the electrophysiologic mechanism is re-entry or circus movement in the AV node and vagal stimulation is making the pathways more refractory. This continues until the tachycardia breaks.

In this case the next two beats are probably idioventricular escape beats. Sinus rhythm then resumes with one remature ventricular beat and later pairs of ventricular beats. These all resolved to normal sinus rhythm spontaneously. Ventricular tachycardia would require three rapid ventricular beats in a row by definition. None of this is evidence for a myocardial infarction. This myocardial irritability following carotid sinus massage is an example of the relatively uncommon excitatory effects of the vagus. These effects are not well understood but may be related to acetylcholine (*Am. Jnl. Card.* 17:240-252, 1966). Carotid sinus massage as a rule is a safe and diagnostically helpful maneuver. However, these uncommon effects should be kept in mind. These usually resolve spontaneously but a bolus of lidocaine may be needed occasionally. ▶



# the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLoGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



Figure 1

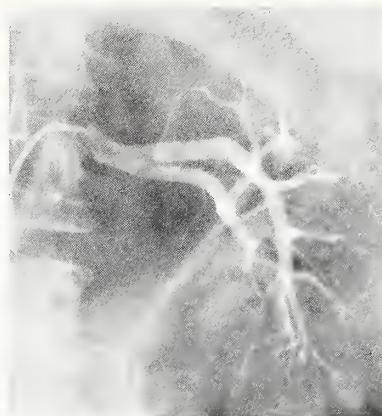


Figure 2



Figure 3

The patient is a 57-year-old male with history of intermittent hematuria of two weeks duration. What's your diagnosis? (Answer on page 143)

## Clinics for Crippled Children Listed for September

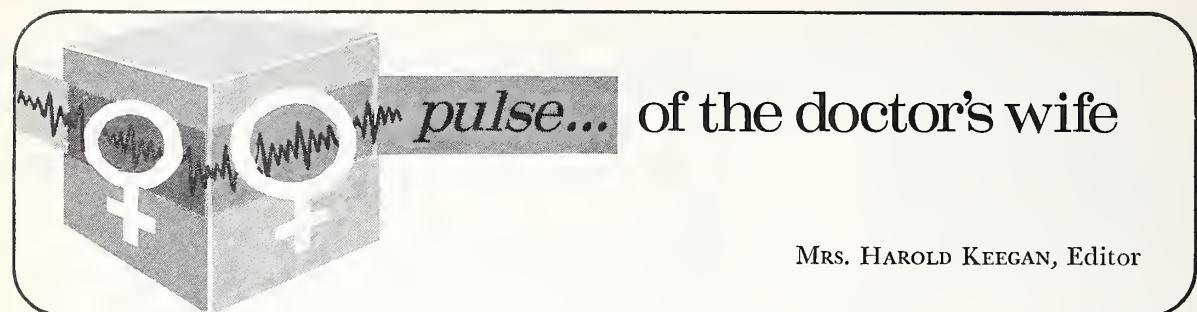
Twenty-eight clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 22 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cardiac conditions. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Sept. 4 Hinsdale—Hinsdale Sanitarium
- Sept. 5 Sterling—Sterling Community Hospital
- Sept. 5 Effingham—St. Anthony Memorial Hospital
- Sept. 5 Lake County Cardiac—Victory Memorial Hospital
- Sept. 9 Peoria Cardiac—St. Francis Children's Hospital
- Sept. 10 Peoria—St. Francis Children's Hospital
- Sept. 10 East St. Louis—Christian Welfare Hospital
- Sept. 10 Carmi—Carmi Township Hospital
- Sept. 11 Champaign-Urbana—McKinley Hospital
- Sept. 11 Joliet—St. Joseph's Hospital
- Sept. 12 Springfield—St. John's Hospital
- Sept. 12 Macomb—McDonough District Hospital
- Sept. 13 Chicago Heights Cardiac—St. James Hospital
- Sept. 17 Belleville—St. Elizabeth's Hospital
- Sept. 17 Rock Island—Moline Public Hospital
- Sept. 17 Decatur—Decatur Memorial Hospital
- Sept. 18 Jacksonville—Norris Hospital

- Sept. 18 Evergreen Park—Little Company of Mary Hospital
- Sept. 19 Rockford—Rockford Memorial Hospital
- Sept. 19 Elmhurst Cardiac—Memorial Hospital of DuPage County
- Sept. 19 Anna—Union County Hospital
- Sept. 23 Peoria Cardiac—St. Francis Children's Hospital
- Sept. 24 Peoria—St. Francis Children's Hospital
- Sept. 24 Alton—Alton Memorial Hospital
- Sept. 25 Centralia—St. Mary's Hospital
- Sept. 25 Chicago Heights—St. James Hospital
- Sept. 25 Elgin—Sherman Hospital
- Sept. 27 Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children. □



MRS. HAROLD KEEGAN, Editor

## Chicago 1974



Delegates and alternates to the Woman's Auxiliary to the American Medical Association who participated at the convention held in June in Chicago were first row: (left to right) Mrs. Wendell Roller, Mrs. Eugene Vickery, Mrs. Thomas Glatter, Mrs. Robert R. Hartman, and Mrs. Edward Szewczyk.

The WA/AMA convention was called to order by the President, Mrs. Willard C. Scrivner, East St. Louis. A keynote address was given by Joyce Brothers, Ph.D., a well-known columnist, radio and television personality. Dr. Brothers directed her remarks to the future of the family.

Other speakers included Birgina Apgar, M.D., Ph.D., Senior Vice-President, National Foundation-March of Dimes; W. Phillip Gramm, Ph.D., Professor of Economics, Texas A&M University; and Robert Kaplan, Ph.D., Professor and Chairman, Health Education Division, Ohio State University.

Mrs. Howard Liljestrand, of Hawaii was in-

stalled as National President by Mrs. C. Rodney Stoltz, national past president. In her address Mrs. Liljestrand stressed health education, alertness to community needs, increased membership and that the county auxiliary is where the service starts.

Two stars of the convention were our own Mrs. Sherman C. Arnold and Mrs. Robert Hartman, Chairman and Vice Chairman, respectively of the Committee on Local Arrangements.

At the close of the convention, Mrs. Willard C. Scrivner, immediate WA/AMA Past President, was welcomed back home.

## *Salute to Our Vice Presidents*



*Elizabeth Davis*



*Betty Szewczyk*



*Jane Klaren*

**Mrs. Ralph F. Davis**, our new Vice President of Membership, has been active on the state level by serving two terms as District 6 Councilor and also as Chairman of Mental Health. In the Adams County Auxiliary, Elizabeth has served as President, Chairman of AMA-ERF, Home Centered Health Care, Press and Publicity, Program, Membership and Treasurer.

A former nurse, Elizabeth retired to become a fulltime homemaker. She has three children ranging in age from 14 to 21 years. Her husband, Ralph, maintains a private practice in radiology in Quincy. Amidst her busy schedule, Elizabeth still finds time to be involved in various church, school and civic projects.

**Mrs. Edward Szewczyk**, Belleville, is a very busy wife, mother and Auxiliary member. Betty and Ed, an ophthalmologist, have six children ranging from 8 to 23 years. As a member of the St. Clair County Auxiliary she has been active for 19 years and has served as President. Her past experience on the state level include Corresponding Secretary, Chairman of WA/SAMA and now Vice-President of Community Health.

Prior to her marriage Betty worked as a writer and program director in radio. She recently was elected President of the Family Service Agency of Southwestern Illinois. Even with this schedule she still has time to be a buyer for a dress shop of which she is part owner.

**Mrs. Earl Klaren**, Libertyville, a charter member of the WA/Lake County Medical Society, has served on their board since its inception in 1956. At the present time she is Benevolence Chairman. On the state level in addition to her present position as Vice-President of Programs she has been Chairman of AMA-ERF for three years.

Jane, the mother of five children and one foster daughter, recently became a grandmother for the first time. Besides being the wife of a surgeon on the staff at Condell Memorial Hospital, she is quite active in her community by serving on school and hospital boards, 4-H leader and working with retarded children.

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### **District Meetings**

|              |                |             |                       |
|--------------|----------------|-------------|-----------------------|
| September 10 | District 4     | Rock Island | Place to be announced |
| September 17 | District 5 & 6 | Pekin       | Pekin Country Club    |
| September 19 | District 1 & 2 | Elgin       | Holiday Inn           |
| September 27 | District 11    | Joliet      | Place to be announced |



## Convention '74

The "Housestaff News" is a new feature in the IMJ designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

Housestaff physicians from across the nation met at Chicago's Palmer House for the 123rd annual convention of the American Medical Association in June. These house officers, representing fully one-fifth of the nation's practicing physicians, devoted much of their time to discussions of the problems facing many of them in their training program as well as the problems facing American medicine today. In addition to the well-publicized issues of PSRO and national health insurance, several issues of primary importance to housestaff officers were discussed.

The report of the Committee on Goals and Priorities (GAP) of the National Board of Medical Examiners was considered and uniformly condemned by the housestaff in attendance. This report, if accepted, would prohibit licensure of any physician until the completion of all aspects of specialty training (see *IMJ*, May, 1974). Many AMA members joined housestaff physicians in condemning certain parts of the GAP report.

The question of due process and fair professional relationships between training institutions and house officers was raised repeatedly during the convention. In testimony before the Interns and Residents Business Session and before the Reference Committee on Medical Education, several housestaff officers described incidents in their own training hospitals which appeared to be flagrant violations of the principles of due process. The AMA, which has supported the concept of due process for many years, listened to these discussions and gave them careful consideration. From these deliberations and from some advance research, a document entitled "Fair, professional relationships between training institutions and house officers" was developed. The document has been forwarded to the AMA Council on Medical Education for study. The document outlines the essentials of professional relationships, noting in particular, the distribution of accurate information to prospective applicants, accreditation and evaluation, and disciplinary actions (due process). It is

hoped that this document will soon become available to all housestaff physicians and will be included in the "Essentials of Approved Residencies."

Perhaps the most important housestaff issue discussed at the convention was the "Guidelines for Housestaff Contracts," a document prepared jointly by the Committee on Housestaff Affairs, members of the Board of Trustees of the AMA, and the legal council to the AMA. While not an actual contract, the document provides information for the development of housestaff contracts and outlines many of the issues which may apply to individual training institutions. These issues include:

- Obligations of housestaff
- Obligations of the institution
- Salary for housestaff
- Hours of work
- Off-duty activities
- Vacations and leave
- Insurance and professional liability
- Grievance and disciplinary procedures

Several hours of testimony were heard, both pro and con at the Reference Committee on Medical Education. After due deliberation, the House of Delegates of the AMA directed that the document be given careful study by a number of the AMA councils and that the Board of Trustees issue a final report at the clinical convention at Portland in December. At that time, the final draft of the document should be available to all housestaff physicians.

The growth of housestaff membership in the AMA and the participation of housestaff physicians in organized medicine in the past few years is unprecedented. The many house officers who participated in the Chicago convention are to be commended for voicing their opinions and helping to mold the future of American medicine. The thoughts and feelings of participating housestaff officers are being heard and considered. Unquestionably, these activities are influencing the course of organized medicine throughout the country. ▶

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# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.*

**ALEDO:** Mercer County, 17,000 population, needs additional family physicians. 4 active physicians at present. General acute hospital in Aledo. High quality medical care economically rewarding. Thirty miles from metropolitan quad-city area. Good small community for family living. Contact: Shirley Lindberg or Monty McClellan, M.D., 308 NW Fourth Street, Aledo, 61231, 309/582-5156. (10)

**BLOOMINGTON:** General Practitioners, Internists, Pediatricians and a Surgeon needed to help establish a multi-specialty clinic in a new Erdman Building. Corporate practice with all the usual benefits. Contact: Paul G. Theobald, M.D., #1 Medical Hills Dr., Bloomington, 61701, 309/828-6051. (10)

**CHARLESTON:** Small midwestern University Health Service serving 8,000 students, 4½ day week; no after hours or weekends. Perfect for post-retirement. Five weeks vacation and one week for medical meetings. Life insurance, health insurance, and University Retirement System. Contact: Director, Health Service, Eastern Illinois University, Charleston, 61920, (217) 581-3013. (10)

**CHENOA:** Rural area, 100 miles south of Chicago on I-55. Looking for one or two physicians to do family practice. Hospital facilities nearby. Financial assistance and office space can be arranged. Contact: R. J. Walker, National Bank of Chenoa, Chenoa, 61726, 815-945-2311. (10)

**CHICAGO:** Board Certified or eligible, Internal Medicine, Illinois Registration. Medical Center, providing preventive and therapeutic medical care with other specialists and diagnostic services on premises. Administrative Ability an Asset, Salary Open, Commensurate with background and experience. Call Collect: William A. Hutchison, M.D., Union Medical Center, 1657 West Adams, Chicago, 60612, (312) 829-1134. (10)

**CREVE COEUR:** M.D. URGENTLY NEEDED as an associate in a very active practice in the Peoria area. hospitals. Present M.D. wishes to retire soon and is Family or General Practice within six miles of three hospitals. Present M.D. wishes to retire soon and is concerned with his patients. Financial arrangements and over-all needs negotiable. Only those seriously interested in private practice call collect 309-699-8022

or 309-699-5525 or write William Long, M.D., Creve Coeur, Ill, 60601. (2)

**DEKALB:** Northern Illinois University Health Service needs Internist; General Practitioner; and Gynecologist or practitioner with wide experience in gynecology and family planning. Reduced paper work, better hours, inquiring patients, new health care delivery systems, and University atmosphere provide interest. Illinois license required. Equal Opportunity Employer. Write L. W. Akers, M.D., Director. NIU Health Service, DeKalb 60115. (10)

**FLORA:** Population 6,000, Patient-drawing area larger. G. P., Internist, Pediatrician. Group or solo. Office space can be arranged to suit your needs. Unusually well-equipped small hospital with excellent lab and X-ray facilities and ICU. Nearby specialty consultants. Fine school system and availability of homes. For information contact: Administrator, Clay County Hospital, Flora, 62839, 618-662-2131. (10)

**GENESEO:** Family Practice; Ped., Ob-Gyn, Int. Medicine who will also do General Practice. Population 7,000 serving area 30,000 on Interstate 80, 2½ hrs. from Chicago, 25 miles from Quad-Cities metropolitan areas, over 300,000. Safe, ideal, small city living, 110 bed ultra-modern hospital, excellent schools, recreational facilities. Hospital has just completed construction of two new modern doctor's offices on hospital property which are available immediately. Guarantee monthly gross income. Clement G. McNamara, 210 W. Elk St, Geneseo, 61254. Call collect (309) 944-6431. (10)

**HARVARD:** Population 5,200, estimated trading area 20,000. Three physicians at present, previously five. Center of rapidly growing and financially sound area. 65 miles northwest of Chicago, 30 miles east of Rockford. Contact: J. M. Holcomb, Harvard Com. Hosp., Grant & McKinley Sts., Harvard, 60033. (10)

**KEOKUK.** Expanding Clinic with new offices in progressive general hospital offers exceptional opportunity to G.P.'s Internists/Cardiologists, General Surgeon willing to do some G.P. Guaranteed salary, no investment. Group membership one year or less. Surgeon, G.P., OB/Gyn, Pediatrician. Ideal environment. Community 16,000; service area 50,000. Contact Fred

Shrimpton, Administrator, St. Joseph Hospital, Keokuk, Iowa 52632, 319-524-2710. (12)

**LIBERTYVILLE**—Thirty-Five miles northwest of Chicago. Population 12,000—serving 40,000. Group practice of Family Physicians. Affiliated with a 175 bed hospital. Corporation benefits. Salary guarantee. Beautiful country for lake sports. Contact: Dr. Mark Fields, 716 S. Milwaukee Rd., Libertyville 60048, 312-362-1390. (10)

**METROPOLIS**: Physicians wanted. Complete office facilities. Financial assistance available. Modern, well equipped hospital serving tri-county area in scenic southern Illinois. Contact: Charles Russell, Administrator, Massac Memorial Hospital, Metropolis, 62960, (618) 524-2176. (10)

**MONMOUTH**: Services area population 30,000. Opening for Family Practice and OB-GYN. Modern well-equipped hospital—141 beds. Near Highways I-74 & I-80. Daily rail to Chicago. Flight service available. Safe place to raise family. Near medical school, liberal arts college. Contact: Roger E. Gurnholt, 1000 W. Harlem Ave., Monmouth, 61462. 309-734-3141. (10)

**PITTSFIELD**: Need family practitioners and surgeons interested in locating in rural community area. Population 4100; area 18,000. Excellent opportunity for someone wanting to practice in a rural community. Located between Jacksonville and Quincy, on Highway 54 and 36. Contact Dr. T. C. Bunting, Illini

Community Hospital, Pittsfield 62363. AC 217-285-2141 or 217-285-2113. (12)

**SAVANNA**: Pediatrician, Internist, or General Practitioner. Illinois community of 5,000 population on Mississippi River. 40-bed open staff hospital; exceptional recreational facilities; excellent schools and churches of all denominations. Option to practice alone or in partnership. Contact: William J. Dayton, 202 Meadowview Knoll, Savanna, 61074, 815-273-2755. (10)

**SHELBYVILLE**: Population 6,000—drawing population 22,000. New eight man medical ctr. recently opened and attached to 100 bed hospital. Object to secure a medical practice group. Central location within commuting distance of Springfield—60 miles, Decatur 35 miles & St. Louis 115 miles. Located on large lake recreational area. Contact: John Snyder, Shelby County Memorial Hospital, 1st & Cedar Sts., Shelbyville, 62565, 217-774-3961. (10)

**SPRINGFIELD**: Emergency Room Physician, Join 4 permanent staff physicians at a progressive 580 bed general hospital in Central Illinois. Attractive salary and benefits. Enjoy the relaxed atmosphere in this 92,000 population city. Practice medicine without the worries of office employees and accounting. Contact Arthur Lindsay, M.D. Memorial Medical Center, 1st and Miller Streets, Springfield, Illinois 62705. 217-528-2041. (12)

## LOW-COST GROUP INSURANCE ANOTHER **ISMS** MEMBERSHIP PRIVILEGE

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## Obituaries

••**Apfellach, George L.**, Chicago, died June 19 at the age of 89. He graduated from Northwestern University in 1910.

•**Bina, Francis**, Belleville, died February 17 at the age of 55. Dr. Bina graduated from the Chicago Medical School in 1947.

••**Collins, John J.** Chicago, died June 10 at the age of 74. He was a graduate of Loyola Stritch School of Medicine.

••**Crispin, Samuel G.**, Danville, died June 17 at the age of 89. He graduated from Loyola Medical School in 1922.

•**Doescher, Paul F.**, Chicago, died June 17 at the age of 75. He was a graduate of Northwestern University in 1926. Dr. Doescher was a staff member of Garfield Park Hospital for 50 years.

••**Edison, Arthur I.**, Chicago, died June 20 at the age of 87. Dr. Edison graduated from the Chicago College of Medicine and Surgery in 1914.

•**Head, Jerome Reed**, Evanston, died June 11 at the age of 81. Dr. Head graduated from the Harvard Medical School, Boston, in 1922. He was associate professor emeritus of Surgery at Northwestern Memorial Hospital and a founder and member of the American Board of Thoracic Surgery. Dr. Head was also a past president of the Board of the Suburban Cook County Tuberculosis District.

••**Krauss, Thomas F.**, Rockford, died June 20 at the age of 82. He graduated from Rush Medical College in 1922.

•**Larson, Myron W.**, Aurora, died June 9 at the age of 63. He graduated from Illinois University in 1937.

•**Meyer, George E.**, Belleville, died April 1973 at the age of 69. He graduated from the Washington University, St. Louis, in 1930.

•**Richards, Charles S.**, Rockford, died Jan. 13 at the age of 39. Dr. Richards graduated from Downstate Medical College, Brooklyn, New York, in 1962.

•**Shapiro, Sherman L.**, Chicago, died May 29 at the age of 79. He graduated from the University of Illinois in 1925. Dr. Shapiro also was a past president of the Chicago Laryngological and Otological Society.

••**Sheehe, Norman L.**, Rockford, died at the age of 82. He graduated from the Albany Medical College in 1917.

••**Sokoloff, Anna**, Chicago, died June 6 at the age of 80. She graduated from Loyola Stritch School of Medicine in 1918.

• Denotes member of ISMS

•• Denotes member of 50-Year Club of ISMS

## View Box

(Continued from page 137)

DIAGNOSIS: *Hypernephroma of the upper pole* of the left kidney. In Figure 1 (nephrotomogram) an abnormal hump is demonstrated on the medial aspect of the upper pole. Figure 2 (a selective left renal arteriogram) suggests some abnormal vascularity in the left upper pole. Figure 3 represents a study after the administration of 12 u.g. of epinephrine into the renal artery catheter. This caused a decreased flow through the vessels supplying normal parenchyma. The tumor vessels however, are densely opacified. Experience indicates that epinephrine angiography is of major usefulness in enhancing the quality of demonstration of renal carcinoma. The most accepted theory is the presence of elastic fibers causes a marked vaso constriction in normal circulation, but their absence in tumor vessels results in a marked increase in vascularity in the region of the tumor. □

### Reference

Kahn, P. C., The Epinephrine Effect in Selective Renal Angiography, *Radiology*, 85:301, 1965.

## In Favor Of Sports

The fundamental plinth on which our policy rests is the assumption that sport is a natural, worth while, and enjoyable form of human expression and eminently deserves support *in its own right and for its own sake*. I would not like to try to imagine a world in which there were no games to play, no chance to satisfy the natural human impulses to run, to jump, to throw, to swim, to dance. The Arts Council, the proponents of music, painting, and literature, do not seek to justify these things by pointing to some superior good. They regard music and painting as in themselves eminently worth while and desirable. And this, I suggest, is how we should look on physical recreation.

The historic Physical Training and Recreation Act 1937 originated from a British Medical Association report on the declining fitness of the population. As one reads the Commons' debate on this Bill it is like passing through a desert and suddenly stumbling on an oasis to come on Aneurin Bevan's blunt and pithy answer to those whose support of the Bill was in terms of its beneficial side effects: ". . . the desire to play is a justification in itself for playing." "Compulsory enjoyment comes near to being a contradiction in terms," the Wolfenden report remarked. We do, however, want to inspire everyone to wish to take part by making the choice irresistible in its scope and variety. The whole focus of our policy is on providing opportunities for participation and, above all, opportunities for all. (Roger Bannister: Sport, Physical Recreation, and the National Health. *Brit. Med. Journal* (Dec 23) 1973, pgs. 711-715.).

# CLASSIFIED ADVERTISING

## Positions & Practice Opportunities

**IMMEDIATE FAMILY PRACTICE OPENING**—in two man clinic. Libertyville, Illinois, 35 miles northwest of Chicago. Initial salary and early partnership. Busy practice in small suburban town. Call collect—Dr. Lawrence C. Day (312) 362-1447.

**ATTENTION PHYSICIANS! CHICAGO MEDICAL CENTERS**—Welfare area in need of physicians. Please contact: Mr. Robert Fields (312) 236-2555.

**GENERAL INTERNISTS and GENERALISTS:** For growing sub-sections of 45 man medical department, including allergists, psychiatrists, neurologists, all sub-specialties and expanding primary care section. Multispecialty group of 120. Large patient population and area referral. Functioning HMO. Generous salary and fringe benefits. Peaceful setting near Wisconsin vacationland and cities. Good schools, cultural advantages, Junior College. Educational and research programs. Liberal schedules, little practice pressure. New Clinic and hospital developing. Write or call J. L. Struthers, M.D., Marshfield Clinic, Marshfield, Wisconsin 54449.

Immediate opening for **Ob-Gyn** and **Internal Medicine**, specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

**PRACTICE and OFFICE AVAILABLE**, about August 1, 1974, in a growing central Illinois town. Size 10,000, local hospital 75 beds, and 6 area nursing homes. Principally GP, OB, Geriatrics & industrial practice. Price Negotiable. Present location 35 years. Income \$50,000-75,000. Reason for moving, health and age. Write: Box 831, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, IL 60601.

Well-established, prosperous North-Michigan Avenue, **Chicago Internist practice** available because of sudden death. Sub-specialties in Electrical Cardiography and Allergy. Especially able and loyal staff and equipment also available. Financial information and further detail furnished promptly to interested parties. Contact Richard W. Burke, Attorney, 3220 Prudential Plaza, Chicago, Illinois 60601, (312) 944-2400.

**MEDICAL DIRECTOR** for permanent, fulltime position with a neighborhood health center at the University of Illinois Hospital and Medical School. Academic appointment, excellent salary and fringe benefits. Opportunity for innovative medical care research in systems and manpower. Student and community education programs. Work with inner city population adjacent to the Medical Center complex. **ILLINOIS LICENSE REQUIRED**. Available now. Salary, rank open. Contact Edward A. Lichten, M.D., Prof. & Head, Dept. Prev. Med. & Commu. Hlth., P.O. Box 6998, Chicago, Ill. 60680. Phone, 312-996-7630. The University of Illinois is an Affirmative Action-Equal Opportunity Employer and encourages applications from members of minority groups and women.

**Full Time Physician for Outpatient Department** of Prepaid Health Plan. Five day 40-hr. week, No on call. Located in Central Illinois. New modern facility. Salary open. Tax shelter available. Contact administrator, Wabash Memorial Hosptl Assn., 360 E. Grand, Decatur, Ill. 62525. Telephone: (217) 429-5246.

**GENERALIST** for full time position in university health service; 40-hr. week, no on-call responsibilities; excellent community of 75,000, three local hospitals. Salary negotiable with liberal fringe benefits including 30-day vacation and retirement plan. Illinois license. Write or call: Margaret M. Torrey, M.D., Illinois State University, Normal, Illinois 61761. Phone (309) 438-8655.

**WHY FIGHT PSRO's, HMO's, AND ILLINOIS PUBLIC AID?** Join us—minimal records, short hours, 5 weeks vacation, and 1 week medical meetings. Illinois University Retirement System, Health Insurance, and Life Insurance. Beginning salary \$25,000 and negotiable. Call or contact Director, Health Service, EIU, Charleston, Illinois. Phone 217-581-3013.

**FAMILY PRACTICE AVAILABLE** about Sept. 1, 1974. Excellent set up with high earnings. Western suburb of Chicago. Write to Box 834 c/o Illinois Medical Journal, 360 N. Michigan, Chicago, Illinois, 60601.

## Positions & Practice Opportunities (Cont'd)

**EXPERIENCED, BUSY G. P.** seeking regular hours. Will consider a clinic, hospital E. R. or other. Write Box 833 c/o Illinois Medical Journal, 630 N. Michigan, Chicago, Illinois 60601.

**CASHMERE, WASHINGTON FAMILY PRACTICE** opportunity in two-man office with four doctor week-end rotation. Scenic setting in orcharding valley on east edge of Cascades. Choice mountain and lake recreation and skiing. Vital community with quality schools. Excellent hospital facilities and cultural advantages in nearby Wenatchee. E. A. Meyer, M.D. (Iowa '50) ABFP, 303 Cottage Avenue, Cashmere, Wash. 98815. Tel.: (509) 782-1541.

**EMERGENCY ROOM PHYSICIAN**—Need fifth man to join four full-time physicians interested in acute care medicine. Regular hours, excellent fringe benefits, salary negotiable. 410-bed hospital (community). Medical School affiliation, ER group incorporation under consideration. Contact: John Edmundson, V-P Administration, Rockford Memorial Hospital, 240 North Rockton Avenue, Rockford, Illinois 61101.

**FAMILY PRACTICE:** Replacement for one year while I take a sabbatical. Net earnings are yours. This is an excellent community to live in. Lovely office in Professional Building. If you want to practice Medicine look this over. Down state Illinois. Write to: Box 835. Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

**FAMILY PHYSICIANS**—Unique practice opportunity in an incorporated 28 man group in east central Wisconsin. New clinic facility across the street from 450 bed hospital. Ideal cultural and recreational setting. Opportunity to develop special interests in acute and ongoing adult care and/or industrial medicine. Equal stockholder in one year. Excellent pre-tax fringes. Write Box 836. Illinois Medical Journal, 360 N. Michigan, Chicago, Ill. 60601.

**Large physician group has immediate positions available** for full-time or part-time Clinic and Emergency Room work. Several locations in Chicago and Central Illinois. Salary plus liberal benefits average over \$20.00 per hour for full-time work. Scheduling flexible to meet individual needs. Contact Gene Gaertner, M.D., 153 W. Lake, Bloomingdale, Ill. 312-627-3404.

**ASSISTANT MEDICAL DIRECTOR**—Nation's seventh largest life insurance company is adding to its staff of eight physicians doing medical underwriting. We offer a generous fringe benefits and retirement package, four weeks paid vacation, and 37½ hour work week. If interested, please write or call (collect) Jack A. End, M.D., Medical Director, Northwestern Mutual Life Insurance Company, 720 East Wisconsin Avenue, Milwaukee, WI 53202. (414) 271-1444.

**FAMILY PRACTITIONERS AND INTERNISTS** Full time salaried appointment to Medical Staff at Cook County Hospital with opportunity to practice half time or more in a community clinic. Write or call David Mc L. Greeley, M.D. Health and Hospital Governing Commission, 1900 West Polk Street, Chicago, Illinois 60612. Telephone: 633-8825.

**Full Time Medical Officers** Major Chicago-area hospital has immediate opening for General Practitioners and other specialists; Joint Commission accredited Medical Center; attractive benefits; competitive salary; all shifts available (8-4; 4-12; 12-8); Medical coverage needed for acute care, rehabilitation, skilled nursing and intermediate care levels; Excellent opportunity for professional advancement. Send curriculum vitae to: Ms. T. Higgins, Personnel Manager, Oak Forest Hospital, 15900 South Cicero Avenue, Oak Forest, Illinois 60452.

Applications are invited from board certified pediatricians interested in a full time position in **Ambulatory Pediatrics** at Cook County Hospital. Position will involve responsibilities for teaching pediatrics, house staff and medical students, providing direct patient care to groups of families in both the Acute Care and Comprehensive Care Units and participation in research projects which are in process or may be originated. Illinois license is required, contact: Agnes Lattimer, M.D., Chairman, Division of Ambulatory Pediatrics, Department of Pediatrics, Cook County Hospital, 1825 West Harrison Street, Chicago, Illinois 60612.

# BLUE SHIELD REPORT



## FOR Illinois Physicians

### Utilization and Completion of the Revised Physician's Service Report

Since the Blue Shield Physician's Service Report form was revised and new supplies distributed in May, we have been interested in your response to revisions in the Service Report and whether any of the changes were causing problems in completing the form.

To gather a number of meaningful statistics, we asked our Blue Shield Claims Department to analyze a sampling of claims received the past month. The audit showed the following results:

- Of the 6,000 claims received daily, nearly 40 percent were submitted on the out-dated Physician's Service Report form. While this will not delay a claim, the revised Service Report *should be utilized*. It was designed for our new processing equipment now in operation and its use also involves employee training and orientation in the implementation of the new system.

- Nearly 15 percent of the total claims received are delayed because of errors and omission in completing the forms. Relatively high proportions of the errors and omissions are occurring in the top portion of the new form. Most involve incorrect Group Numbers and Member Identification Numbers. If these numbers are entered incorrectly, our computer is unable to validate a member's eligibility for benefits. *Most delays begin here.*

The most reliable source for membership identification is the patient's Blue Shield Identification Card. Copy the Group and Member ID numbers exactly as they are shown on the card. *Please do not include the codes.*

- The rectangular box to the right, on the first line of the claim form, is reserved for a *patient's account number* given in a physician's office or

clinic. It is *not intended* for membership identification purposes.

- Patient and member names are often spelled incorrectly, transposed on the lines, or the address may be incomplete.

- Information on sex, age, married or single status and patient's relationship to member must be completed. Any one of these data entries, if omitted, will delay a claim.

- Data on "If Accident/Medical Emergency, Give Date:" This information is often omitted, as well as where the accident or medical emergency happened. It must be entered on the claim form.

The above items, because of their importance initially in completing a claim, are circled or underscored in the portion of the Service Report reproduced below.

Other data that is frequently incomplete includes:

- (1) The diagnosis: Give significant descriptions. Please use standard medical nomenclature in surgical procedures if an operation is performed.

- (2) Itemize each service and show total fee for described service. Also indicate whether or not fee has been paid by the patient. This information is especially important so that payment can be made to the physician on the basis of the Usual charges for Blue Shield members protected by our Usual and Customary programs;

- (3) If other physicians have also rendered services *each* must submit his own Physician's Service Report. Please do not use the imprinted Service Report of another physician;

- (4) Signature of the physician rendering the service must be on the Physician's Service Report.



#### PHYSICIAN'S SERVICE REPORT

Blue Shield • Plan of Illinois Medical Service  
233 North Michigan Avenue, Chicago, Illinois 60601 • 661-4200

Group No. & Member ID No. 1947-2368

Patient's Name MARY JONES

Member's Name JOHN JONES

Patient's Account Number

Sex F Age 42  Married  Single

Patient's Relationship to Member: 1  Self. 2  Spouse. 3  Dependent.

and Address 20 EAST 7th STREET - CHICAGO, ILLINOIS 60610

If Accident/Medical Emergency, Give Date: 7-15-74 Happened at: 1  Home 2  Work 3  Auto 4  Other:

## ASK BLUE SHIELD ... ABOUT MEDICARE

# Optional Payment Method for Patients on Maintenance Dialysis; Monthly Payment for Self-Dialysis Patients

### Part II of the Summary

*The new instructions on renal dialysis treatment and payment options issued to Part A intermediaries and Part B Medicare carriers are published at the request of the Department of Health, Education and Welfare.*

*Part I of the instructions was published in the August issue of "Ask Blue Shield About Medicare" and included a discussion of the alternative payment method, the flat fee for self dialysis training, and services covered. The summaries are intended as information on the program to the general medical community. Specific details on the instructions and revisions may be obtained from the intermediary or carrier in your service area (Blue Shield for Part B in Cook County).*

### Services Not Covered

(1) Declotting of shunts.

(2) Physician services to inpatients. The monthly fee is reduced by 1/30 for each day of hospitalization, and the physician may bill on a fee-for-service basis. When inpatient services are furnished, the period between the date of the last outpatient facility dialysis and the next routine facility dialysis is used as the period for which services are subtracted from the monthly billing. If the physician wishes to continue receiving the full monthly payment instead of billing on a fee-for-service basis he may do so, but not bill on an individual basis.

(3) If a patient is dialyzed in an outpatient facility other than his usual facility, and the facility includes charges for "supervisory" services, payment to the attending physician is reduced the appropriate number of days.

(4) Services for an *unrelated* illness either by the physician providing renal care or another physician may be billed on a fee-for-service basis. The physician must provide documentation that the disease is not related to the renal condition and that added visits were required.

(5) Services rendered by other physicians for concurrent care are not covered on the monthly payment basis. The Medicare program permits reimbursement for services on a separate claim, furnished by a second physician in addition to the attending physician if the services meet the definition of consultative services and are determined by the carrier as reasonable and necessary to assist the attending physician in assessing or treating the patient's total medical condition.

Another involving services that would be covered separately occurs when the services of two or more physicians are required for an active role in the patient's treatment because of the presence of more than one medical condition requiring diverse

specialized medical services. All claims involving such concurrent care are reviewed by the carrier to determine whether the services are reasonable and necessary.

### Conditions for Election of Optional Method

(1) Physicians at a facility are free to decide whether they will bill for physicians services to patients under either the current method or monthly payment method. However, all physicians attending patients within a given facility may use only one method and must agree to bill under only one method.

When physicians form a team to provide the monthly continuity of services to a group of patients, one monthly payment would be made for each patient in the group's care.

(2) In facilities where reimbursement is under the current method and physicians elect the monthly method, administrative charges are reduced accordingly.

(3) When a patient is temporarily attended by another physician, it is the responsibility of the primary care physician to share reimbursement. As in the case of an associate attending the patient, the patient cannot be billed twice. If one physician covers for another no modification in reimbursement is involved. If reimbursement must be shared, the physicians make the appropriate arrangement.

### II. Monthly Payments to Patients on Self-Dialysis at Home or in a Facility

The same method for determining the amount of payment is used except the conversion factor is 14, rather than 20. The amount of the factor is less because self-dialysis patients generally do not require as extensive services as patients in facilities who are not on self-dialysis.

Services covered are:

(1) Those furnished during a dialysis session, including back-up dialysis in outpatient facilities;

(2) Office visits for the routine evaluation of patient progress, including interpretations of diagnostic tests and procedures;

(3) Those furnished by the attending physician in the course of office visits, the primary purpose for which is the monitoring or follow-up of complications of dialysis, including services involved in prescribing therapy without increasing the number of contacts beyond those occurring at normal monitoring sessions or visits for treatment of renal complications,

(4) General support services (arranging for supplies, etc.)

Services not covered are the same as those applying to patients on maintenance dialysis described above.



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**In the treatment of edema associated  
with congestive heart failure**

**To counteract  
 $\text{Na}^+$  reabsorption  
and excessive  
 $\text{K}^+$  excretion**

**Add**

# **Dyrenium®**

**brand of triamterene 100 mg. capsules**

**to thiazides and furosemide**

**For increased efficacy of  
diuretic therapy.**

**For decreased risk of digitalis  
intoxication due to potassium depletion,  
which sensitizes the myocardium  
to the toxic effects of digitalis, and  
reduces its inotropic effect**

Before prescribing see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

**Indications:** Edema associated with congestive heart failure, cirrhosis and nephrotic syndrome; steroid-induced edema; idiopathic edema; edema due to secondary hyperaldosteronism and edema resistant to other diuretic therapy.

**Contraindications:** Severe or progressive kidney disease or dysfunction (possible exception nephrosis); severe hepatic disease; pre-existing elevated serum potassium; hypersensitivity to the drug. Continue use in developing hyperkalemia. Do not give potassium supplements either by drug or by diet.

**Warnings:** Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported. Check BUN and serum potassium periodically especially in the elderly, diabetics and those with suspected or confirmed renal insufficiency. Use in pregnancy only when essential to patient welfare.

Dyrenium (triamterene, SK&F and spironolactone are not usually used concurrently. If they are however frequent serum potassium determinations are required.

**Precautions:** If hyperkalemia develops, withdraw the drug. The following may also occur: electrolyte imbalance, low-salt syndrome (with low salt intake), reversible mild nitrogen retention, decreasing alkali reserve with possible metabolic acidosis. Do periodic hematologic studies in cirrhotics with splenomegaly. Concomitant use with antihypertensive drugs may result in an additive hypotensive effect. When 'Dyrenium' is to be discontinued after intensive or prolonged therapy withdraw gradually because of possible rebound kaliuresis.

**Adverse Reactions:** Diarrhea, nausea and vomiting (may indicate electrolyte imbalance), other gastrointestinal disturbances, weakness, headache, dry mouth, anaphylaxis, photosensitivity, elevated uric acid, rash. Note: When combined with another diuretic, the initial dosage of each agent should be lower than recommended.

**Supplied:** 100 mg. capsules in bottles and Single Unit Packages of 100.

**SK&F CO.**

Subsidiary of SmithKline Corporation

## Clinics for Crippled Children Listed for October

Thirty three clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 23 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be seven special clinics for children with cardiac conditions, and three for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

|            |  |
|------------|--|
| October 2  | Springfield Pediatric-Neurology—Diocesan Center                        |
| October 2  | Metropolis—Massac Memorial Hospital                                    |
| October 2  | Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults |
| October 2  | Hinsdale—Hinsdale Sanitarium   |
| October 3  | Sterling—Sterling Community Hospital                                   |
| October 3  | Flora—Clay County Hospital   |
| October 3  | Lake County Cardiac—Victory Memorial Hospital                          |
| October 3  | Cairo—Public Health Department   |
| October 4  | Chicago Heights Cardiac—St. James Hospital                             |
| October 8  | Peoria—St. Francis Children's Hospital                                 |
| October 8  | Carrollton—Boyd Memorial Hospital                                      |
| October 8  | East St. Louis—Christian Welfare Hospital                              |
| October 9  | Champaign-Urbana—McKinley Hospital                                     |
| October 10 | Rockford—St. Anthony Hospital  |
| October 10 | Springfield—St. John's Hospital  |
| October 10 | Kankakee—St. Mary's Hospital   |
| October 11 | Chicago Heights Cardiac—St. James Hospital                             |
| October 14 | Peoria Cardiac—St. Francis Children's Hospital                         |
| October 15 | Quincy—St. Mary's Hospital   |
| October 15 | Rock Island—Moline Public Hospital                                     |
| October 16 | Chicago Heights—St. James Hospital                                     |
| October 17 | Bloomington—Mennonite Hospital   |
| October 17 | Elmhurst Cardiac—Memorial Hospital of DuPage County                    |
| October 22 | Peoria—St. Francis Children's Hospital                                 |
| October 22 | Danville—Lake View Hospital  |
| October 23 | Centralia—St. Mary's Hospital  |
| October 25 | Chicago Heights Cardiac—St. James Hospital                             |
| October 25 | Evanston—St. Francis Hospital  |
| October 28 | Peoria Cardiac—St. Francis Children's Hospital                         |
| October 29 | East St. Louis—Christian Welfare Hospital                              |
| October 29 | Mt. Vernon—Good Samaritan Hospital                                     |
| October 30 | Springfield Pediatric Neurology—Diocesan Center                        |
| October 30 | Aurora—St. Joseph Mercy Hospital                                       |

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

### PROLOID® (thyroglobulin)

**Caution:** Federal law prohibits dispensing without prescription.  
**Description.** Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine ( $T_4$ ) and Sodium Liothyronine ( $T_3$ ). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of  $T_4$  and  $T_3$  in Proloid (thyroglobulin) is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

**Indications.** Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in non-emergency situations, in an attempt to reduce the size of such goiters.

**Contraindication.** Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

**Warnings.** Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

**Precaution.** As with all thyroid preparations this drug will alter results of thyroid function tests.

**Adverse Reactions.** Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

**Dosage and Administration.** Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR,  $T_3$   $^{131}\text{I}$  resin sponge uptake,  $T_3$   $^{131}\text{I}$  red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of  $T_4$  and  $T_3$  is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

**Overdosage Symptoms.** Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

**How Supplied.**  $\frac{1}{4}$  grain;  $\frac{1}{2}$  grain; scored 1 grain;  $\frac{1}{2}$  grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

Full information available on request.



**WARNER/CHILCOTT**

Division, Warner-Lambert Company  
Morris Plains, New Jersey 07950

PR-GP-31-B/W



## *President's Page*

# Federal PSRO vs Illinois Alternative

We are faced with a dilemma.

The decision of several component county medical societies and their affiliated foundations to pursue the federal PSRO initiative rather than the Illinois alternative has challenged the validity of the ISMS position on this critical issue.

Because of these recent developments at the local level, I believe we must reassess the entire PSRO issue—including the ISMS position and its proposed alternative program.

In an effort to resolve our dilemma, the Board of Trustees last month called for an objective evaluation of the situation through:

- An opinion survey—conducted by an outside research firm—to determine physician attitudes on PSRO;
- A special session of the House of Delegates in November to review the survey results and reassess its position on PSRO, and
- An educational program which will outline the implications of PL92-603 and the options available to physicians.

The educational program is extremely important since the schizophrenia displayed by Illinois medicine in dealing with PSRO partially can be attributed to an ignorance of the issues coupled with a misunderstanding of the law and the ISMS position.

In order to achieve the unity necessary to cope with PSRO, I urge each of you to take advantage of this informational program . . . carefully weigh the alternatives . . . and make your feelings known to your delegates.

The House of Delegates must have the benefit of the "grass roots" viewpoint to objectively evaluate its position. You have an opportunity to make your views known on this critical issue. If you fail to seize it, charges that your state medical society refuses to consider your opinion are not valid.

I urge you to participate in the decision making process, and to support the chosen course of action.

# how to civilize the of peptic ulcer...

give pain killers?... prescribe frequent eating?... use antacids only?

## give pain killers only?

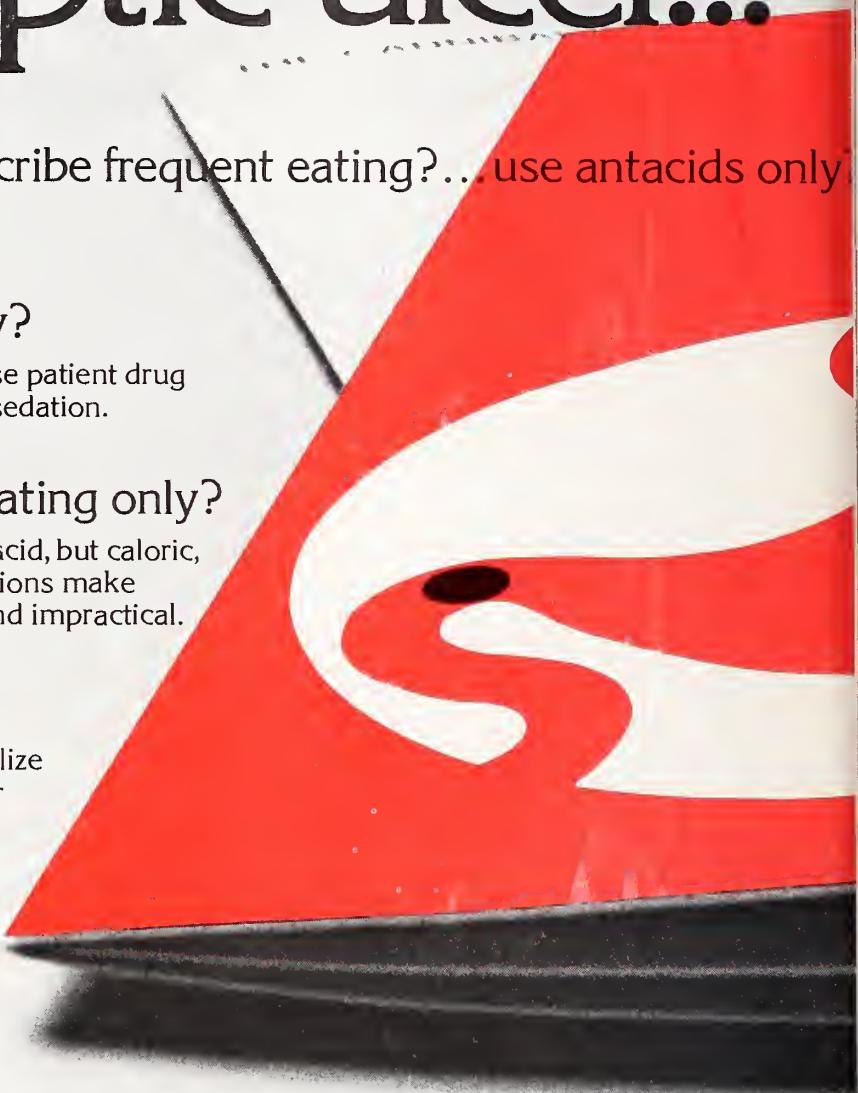
They relieve pain but may cause patient drug dependency and unnecessary sedation.

## prescribe frequent eating only?

Frequent feeding helps buffer acid, but caloric, digestive, and social considerations make frequent eating both difficult and impractical.

## use antacids only?

Antacids, like food, help neutralize or buffer stomach acidity. Their action is short, usually lasting only 1 to 1½ hours (given four hours after a meal).<sup>\*</sup> Some patients may require antacids every half hour.



# When you add Pro-Banthine® you

brand of propantheline bromide

**Indications:** Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

**Contraindications:** Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

**Warnings:** Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle

control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

**Precautions:** Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

**Adverse Reactions:** Varying degrees of drying of salivary secretions may

# *Abstracts of Board Actions*

**August 3-4, 1974**

**Chicago**

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.*

## **Membership Poll on PSRO**

The Board of Trustees authorized Decision Making Information, a Los Angeles opinion research firm, to conduct a study of physician attitudes on PSRO with the results to be presented at a special session of the House of Delegates in early November.

The move was prompted by actions of several groups which have challenged—apparently with the support of county medical society leadership—the House of Delegates' directive to refrain from involvement in the federal PSRO initiative.

Beginning early next month, Decision Making Information will survey by mail a scientifically-selected sampling of ISMS members to determine what role, if any, ISMS should play in implementing PL 92-603.

In response to a letter signed by the presidents of Chicago, Quad River and Northern Illinois Foundations for Medical Care, the Board indicated—unless otherwise directed by the House of Delegates this fall—it will:

- Proceed with the development of IPSRO in accordance with House of Delegates directives.

- Refrain from controversial activity in areas where local foundations have received or applied for federal PSRO planning grants except when called upon for assistance by local medical societies in those areas.

- Reject involvement in the federal PSRO regulated program in accordance with the House of Delegates directives.

In related action, the Illinois Foundation for Medical Care—at the request of local PSRO applicants—agreed to establish a unified data system suitable for use by local medical care foundations or reviewing units in the various type programs now under consideration.

## **Committee on National Health Insurance**

The Board directed the Governmental Affairs Council to set up a subcommittee to study national health insurance proposals and all major national health legislation. This committee is expected to utilize the expertise of those ISMS members serving on the AMA Speakers Bureau for National Health Insurance.

## **Recommendations For AMA Appointments**

The following have been recommended for appointment to AMA councils and committees:

Drs. Alfred J. Faber, Glenview, Legislation; Edward A. Piszczeck, Chicago, Environmental, Occupational and Public Health; Jack Gibbs, Canton, Health Manpower; Kermit Mehlinger, Chicago, Alcoholism; Donald Stehr, Havana, Rural Health; Robert T. Fox, Glenview, Scientific Assembly; Robert C. Stepto, Chicago, Cancer; Julius Kowalski, Princeton, Exercise and Physical Fitness; Robert R. Hartman, Jacksonville, Maternal and Child Health; Bernard Cahill, Peoria, Medical Aspects of Sports; Ralston Hannas, Evanston, Community Emergency Services; Trudy F. Eisenman, Chicago, Cutaneous Health and Cosmetics; Fred Z. White, Chillicothe, Nursing; William M. Lees, Lincolnwood, Quackery; T. Vaithianathan, Skokie, Transfusion and Transplantation, and Joseph O'Donnell, Glen Ellyn, Subcommittee on Health Care Financing.

## **AMPAC Board Vacancy**

Willard C. Scrivner, M.D., Belleville, has been nominated to replace Frank J. Jirka, Jr., M.D., River Forest, on the AMPAC Board of Directors. The vacancy was created by Dr. Jirka's recent election to the AMA Board of Trustees.

*(Continued on page 210)*



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## Personal History of Paget's Disease Osteitis Deformans With Several Unusual Features and Their Control

BY REUBEN BARD, M.D./BAY HARBOR ISLAND, FLA.

As a physician I have been in the unique position of observing the development and course of Paget's in myself over a period of 40 years. For the first 20 years it appeared progressively in many of my bones and the symptoms became severe and complicated. It reached the stage where I was almost always miserable and worked under duress. Then, in 1952, after much investigation a program of therapy was evolved giving me almost complete relief. Thus, for the past 20 years I have been well enough and keen enough to again function as a busy physician.

The first evidence of Paget's was found in my pelvic bones, on X-rays in 1933, made in a check-up examination for a ureteral calculus. Later it was found in my skull, the bones of the shoulder and hip areas, and then in two lumbar vertebrae.

My head has been growing larger and continues to do so. The largest circumference is 26.5 inches. Early X-rays showed osteoporosis circumscripta, but this was less evident later. More pronounced since has been a growing number of irregular and circular areas of increased density affecting the outer table and diploe, and sub-

sequent thickening of the bones. By 1962 the X-rays showed the diploe to be three times the normal thickness. The sella turcica is large but not diseased. There is flattening of the base of the skull, and possible platybasia. Laminography of the skull, to check deafness in the right ear, disclosed increased density of the cochleae, with thickening of the bony walls, more pronounced on the right.

The hard palate and superior maxilla protrude forward producing a prognathism that continues to increase even now. The upper teeth extend one-half inch beyond the lower teeth with a separation and palato-version of the ones in the left jaw. There is now an especially wide space between the first two upper incisors.

X-rays in 1940 showed a marked kyphosis in the lumbar area, and Paget's changes were found later in the second and third lumbar vertebrae. These are now dense, compressed and widened. There is a slow spreading of Paget's in the humeri, the scapulae and the clavicles, and in the major bones of the pelvis.

Also in 1940 X-rays showed groups of small calcifications outside the bones in both shoulders, one elbow and both hips. Such calcifications cleared and recurred repeatedly until 1952.

I had symptoms typical for Paget's such as backache and pains in the hips and down the legs. But my more distressing ones were atypical

REUBEN BARD, M.D., is a retired general practitioner. At the time of writing, Dr. Bard resided in Evanstan. He is a graduate of the University of Illinois College of Medicine and was a member of the American Academy of Family Physicians.

and not described in the literature on the subject. They include episodes of severe distress in the shoulders or the hips, similar to calcified bursitis or tendinitis. They usually followed such activities as golfing or bowling, and were sometimes severe enough to confine me to bed. While headaches are usually ascribed to the skull involvement, I have noted that my headaches were due to another physiologic phenomenon. They were frequent and persistent, usually supraorbital, but often involving the entire head. They appeared irregularly, unrelated to time, activity or emotional state, and were associated with progressively worsening mental dullness, declining perception and impaired memory. I could not concentrate and my working efficiency deteriorated appreciably.

Between the years 1928 and 1952 I had many attacks of renal colic, followed by the passage of small, rough, dark red stones less than 2 mm. in size. None was large enough for chemical analysis at that time. In 1952 probenecid (Benemid®) was prescribed for another reason, and there were no new calculi since. The exception was a fragmented calculus low in the left ureter removed by transvesical ureterotomy at the Mayo Clinic in March, 1954. The chemical analysis revealed calcium oxalate.

Neuritis appeared in 1948 and continued to 1952. It was associated with widely distributed areas of numbness, cold or warmth, and itching or pins and needles sensations. The latter were most distressing over the nose, ears and cheeks. There was burning of the tip of the tongue, my ears felt stuffed, and my throat had the sensation of a swollen uvula. I had a metallic taste. There were scattered subcutaneous fasciculations, and muscle cramps in the legs and feet. Later on the occurrence of sharp shooting pains through the perineum would make driving a car difficult.

Pronounced visual difficulties also occurred. As I read, the words changed from clear to blurry and did not remain in focus. After a few minutes of reading the distress became too difficult to continue reading. Many ocular studies and corrections of refractive errors were only slightly helpful. The ophthalmologic findings were narrowing and tortuosity of the retinal arteries. A study in February, 1972, at the Bascom Palmer Eye Institute in Miami, Florida, did not reveal angiod streaks.

Additional symptoms such as tinnitus and decreased hearing in the right ear may be related to the Paget's. My current cardiac problems are considered due to coronary heart disease, and

despite a continuing high blood volume, the early signs of decompensation are not believed to result from a high output failure. Blood pressure has always been low, 120/64. Blood counts have always been within normal.

When my bone pains were mild I got relief with such non-narcotic analgesics as aspirin or amidopyrine (Pyramidon®) and later when the joint pains were severe I got fair relief by injections of procaine into the painful areas. This was a procedure I used in the many cases of bursitis and subacromial tendinitis I saw frequently in the war years of 1941 to 1945. That was in the era as described by Jaffe<sup>1</sup> when "treatment was merely symptomatic and palliative" and even as recently as 1972, despite the possible breakthrough in therapy with the many new drugs under investigation, Ingelfinger<sup>2</sup> called Osteitis Deformans a "have not" disease that causes little stir.

At one time my headaches were relieved with ergotrate and caffeine (Cafergot) but when as many as four tablets a day were only partially effective, I stopped using them as I feared possible ergot effect on my arteries. At such times the temporal arteries were very distended and the pulsations were visible.

Early in 1952 I made a concentrated investigation to seek help and saw several medical authorities. The Director of the Oklahoma Medical Research Institute and Hospital in Oklahoma City advised me to use a moderate calcium intake in my diet, Vitamin C one-half gram twice a day, and a high liquid intake.

On October 15, 1952, I was admitted to the Max Pam Research Unit at Michael Reese Hospital, Chicago. It was determined that I had a high blood volume (See Table 1). Blood volume determinations since then are included in Table 1. The blood uric acid was found to be 8.0 mg.% (See Table 2). My attending physician told me that "a uric acid of 8 meant hyperuricemia, and that meant gout."

A neurologic study<sup>3</sup> revealed "sensory dysesthesias existing practically everywhere in the body, but chiefly over the trunk and the lower extremities." Later when I was under care in the Mayo Clinic, Rochester, Minnesota, in March 1954, a neurologic study showed no remnant of the dysesthesias.

I was told that I had both Paget's and gout. As the new uricosuric drug probenecid (Benemid®) was available. I was advised to use it, not only to treat the skeletal symptoms but also to see if it would relieve the headaches.

**BLOOD VOLUME REPORTS**

**10/17/52**

Total Blood Volume      5960 cc (N = 75 - 85/kg)  
 Plasma Volume            3800 cc (N = 42 - 46/kg)  
 Red Cell Mass            2160 cc

**ISOTOPE 1/2/64**

Total Blood Volume      6200  
 Blood Volume/kg          86.1  
 Red Cell Mass/kg        34.4 (N = 30 ± 5)  
 Plasma Volume/kg        51.7 (N = 38 - 48)

**ISOTOPE 6/23/69**

Whole Blood              5600 (N = 4900)  
 Red Cell Volume          2150 (N = 2020)  
 Plasma Volume            3450 (N = 2880)

**7/15/70**

Whole Blood              6575 (N = 4800)  
 Red Cell Volume          2520 (N = 1920)  
 Plasma Volume            4059 (N = 2820)

**Table 1 shows all available reports on blood volume studies.**

It must be noted that the coexistence of Paget's and gout, while not common, has been reported at various times.

Paget<sup>4</sup> in his first report on the disease recorded three cases with gout. Talbot<sup>5</sup> in his book GOUT lists the reports he found by several authors. Barry<sup>6</sup> in his book devoted only to Paget's makes slight reference to its occurrence.

My response to the probenecid was surprising and dramatic, even though my headaches were not relieved. In a short period all the neuritides cleared up and my eyes improved and then returned to normal. These improvements have continued more than 20 years. I made a kind of control test on myself in August, 1973. I withheld the medication and ate all foods, including liver. The serum uric acid preceding this test was 4.8 mg.%. After this period of nontreatment it rose to 8.5 mg.%. I had to stop this experiment

(Continued on page 184)

**TABLE 2**

| Date     | Calcium     | Phosphorus<br>mg.% | Alkaline<br>Phosphotase<br>Bodansky | Acid<br>Phospho-<br>tase | Serum<br>Uric<br>Acid<br>mg.% | Glucose                        | Cholesterol |
|----------|-------------|--------------------|-------------------------------------|--------------------------|-------------------------------|--------------------------------|-------------|
| 3-4-40   | 9.15 mg.%   | 3.4                | 9.48                                |                          |                               |                                | 208         |
| 3-23-51  |             |                    | 34.2 *                              |                          | 5.0                           | 106                            |             |
| 2-23-52  | 11.0 mg.%   | 3.5                | 39.4                                |                          |                               |                                |             |
| 10-15-52 |             |                    |                                     |                          | 8.0                           | 74                             |             |
| 7-13-53  | 11.0 mg.%   | 4.0                | 7.0                                 |                          | 3.6                           |                                |             |
| 1-6-55   |             |                    | 11.3                                |                          |                               |                                |             |
| 9-6-55   |             | 6.1                | 22.7                                |                          | 4.8                           |                                | 282         |
| 9-22-58  | 12.0 mg.%   |                    | 17.4                                |                          | 6.6                           |                                | 312         |
| 10-30-59 | 8.5 mg.%    |                    | 27.0                                |                          | 4.4                           |                                | 400         |
| 9-12-60  | 8.6 mg.%    | 4.0                | 49.0                                |                          | 6.8                           |                                | 376         |
| 6-1-62   |             | 2.6                | 19.4                                |                          | 4.0                           |                                | 328         |
| 6-22-63  |             | 2.8                | 16.2                                |                          | 7.4                           |                                |             |
| 12-6-63  | 6.0 m.Eql.  | 3.6                | 32.4                                |                          | 4.0                           |                                | 336         |
| 2-1-66   | 5.2 m.Eql.  |                    | 51.6                                |                          | 6.9                           |                                |             |
| 3-2-67   |             |                    | 11.2                                |                          | 5.8                           |                                | 185         |
| 5-6-68   | 5.25 m.Eql. |                    | 43.0                                |                          | 6.6                           | 137                            |             |
| 2-12-69  |             |                    | 9.8                                 |                          | 6.0                           |                                |             |
|          |             |                    |                                     |                          |                               | Glucose<br>Tolerance<br>Normal |             |
| 5-20-69  | 5.0 m.Eql.  | 3.6                | 37.5                                | .75                      |                               |                                | 319         |

The following three are SMA-12:

|         |           |          |     |
|---------|-----------|----------|-----|
| 8-26-71 | 9.9 mg.%  | Over 400 | 5.7 |
| 4-18-72 | 10.1 mg.% | Over 400 | 5.7 |
| 5-17-73 | 9.3 mg.%  | Over 400 | 4.8 |
| 5-17-73 |           | 30.5 **  |     |
| 8-31-73 |           |          | 8.5 |

\*King-Armstrong   \*\*Bodansky   Note: Urea N (BUN) 13 on 2-12-69

**Table 2 shows a representative list of blood chemistry values.**

# The Bleeding Duodenal Ulcer

BY JAMES R. HINES, M.D., AND LARRY WILKHOLM, M.D./CHICAGO

Approximately 10,000 Americans die yearly of peptic ulcer disease. Most of these deaths are due to hemorrhage and duodenal peptic ulcers account for more than half of all bleeding from peptic ulcer diathesis.

Upper gastrointestinal tract hemorrhage can be divided into massive or moderate bleeding. Massive bleeding is usually defined as bleeding that lowers the hemoglobin to eight grams or less, unstable vital signs after 1,500 cc. of whole blood, or signs of clinical shock.<sup>1-2</sup> Some authors have used the criterion of 2,000 cc. of blood transfusion, a blood pressure drop of 40 mm. hg. below the normal, or a loss of 30% of the blood volume in a three-day period.<sup>3-5</sup> Moderate hemorrhage is one that requires less than three pints of blood and the patient has no unstable vital signs. The latter usually has melena without hematemesis.

Of all massive gastrointestinal tract bleeding only 15-25% is proven to be from a duodenal peptic ulcer.<sup>6</sup> However, when all massive upper gastrointestinal tract hemorrhages are studied, 30% to 60% are shown to be from duodenal ulcers. An average of several series reveals 45% to be proven duodenal ulcers; and another 20% of unknown site.<sup>7-11</sup> A large number of the patients with hemorrhage from an unknown site may have bled from a duodenal ulcer. Municipal and veterans hospitals have a higher percentage that bleed from gastritis, multiple ulcerations, and esophageal varices.<sup>8,12</sup>

## Immediate Management of Massive Hemorrhage

The "four tube" system should be instituted at once.<sup>13</sup> The first tube is a large intravenous line inserted to draw blood for a blood count, to cross match for donor blood and to

start fluids. The second tube is a nasogastric tube to aspirate the stomach. This can be used for ice water lavage to help reduce bleeding, to observe for further bleeding, to measure the gastric acid, and to remove the gastric acids as a method of treatment. The fear that a nasogastric tube will re-start bleeding that has stopped is not justified. When the clinical signs and symptoms point to bleeding esophageal varices, the Blakemore-Sengstacken tube can be substituted for the Levine tube. The third "tube" is an indwelling catheter in the urinary bladder in order to monitor urinary output. The fourth "tube" is a central venous line used to measure the central venous pressure and thus evaluate the balance between blood loss and replacement. These four procedures should be done in the emergency room as soon as the patient is examined. Whole blood should be replaced as it is lost. When the patient's vital signs have stabilized, he can then be removed to an intensive care unit for continuous monitoring. Patients should be taken directly to the operating room if one is unable to restore the vital signs in the emergency room.

## Diagnostic Methods in Massive Hemorrhage

While some patients will have a proven history of a specific disease (such as a duodenal peptic ulcer or esophageal varices) more than half are without a prior diagnosis. Examination of the contents of the nasogastric suction or of the vomitus is helpful. Large, soft dark clots may tend to make one think of bleeding varices. Coffee-ground material is more likely to be from a bleeding duodenal ulcer while a large amount of bright red blood could be from either a gastric or duodenal ulcer. A "vigorous" diagnostic approach can help determine which cases will best respond to surgical management.<sup>14</sup> As soon as the patient's vital signs are stabilized, a barium meal should be ordered. The stomach is aspirated and washed out just before the barium meal. Recent series have shown this examination to be 70% to 75% accurate.<sup>7,8,13</sup> Renewed interest in emergency esophagogastrectomy is due to improved techniques with non-rigid fiberoptic equipment. Reports now estimate 85% accuracy in diagnosis with the new instruments. The com-



JAMES R. HINES, M.D., is Chairman, Department of Surgery, Welsey Pavilion Northwestern Memorial Hospital, Chicago and Professor of Surgery, Northwestern University Medical School. Dr. Hines, a general surgeon, has developed the Hines pyloroplasty for peptic ulcer surgery.

LARRY WILKHOLM, M.D., is an Instructor in Surgery of Northwestern University Medical School.

bination of barium meal plus esophagogastroscopy has been estimated to be 95% accurate.<sup>6,13</sup>

Angiography has been useful in patients with obscure lesions<sup>15</sup> and in selected cases.<sup>13</sup> Blood loss must be in excess of 1 cc. min. for this test to be of value.<sup>9</sup> Liver function tests, especially the BSP, are helpful in cases of suspected liver damage with bleeding esophageal varices.

We now employ both the emergency upper GI X-ray and emergency esophagogastroscopy in undiagnosed bleeding. Angiography has been used infrequently in massive bleeders but has been helpful in those patients that have had repeated bleeding episodes.

### **Non-Operative Management of Massive Bleeding**

Whole blood should be replaced as it is lost. The practice of allowing the patient to remain hypovolemic and hypotensive in order to enhance clotting and to limit rebleeding is not justified.<sup>16</sup> Inadequate perfusion of the vital organs leads to strokes, myocardial infarction, pulmonary failure, renal tubular necrosis and hepatic failure, as well as to fatalities from exsanguination itself. A coagulation profile should be obtained and any deficiencies corrected.

Ice water lavage of the stomach is helpful, especially in patients with gastritis or multiple bleeding sites, as vasoconstriction is induced by the iced water or saline. Local vasoconstrictors induced through the Levine tube have had little success.

While most authors believe that continuous gastric aspiration is indicated in massive hemorrhage, a few feel that instillation of antacids through the Levine tube is helpful. This has been used in patients that are considered unsuitable candidates for any surgical procedure. An alternate method is to instill antacids for three hours and to aspirate the fourth hour. Anticholinergic drugs have been given by parenteral methods but their value is questionable. Sedatives are helpful.

Vasoconstrictors have been infused directly into the gastric arteries by arterial catheterization.<sup>17,18</sup> This is especially practical if the catheter is already in place for diagnostic angiography. Large doses of norepinephrine have been infused into these vessels without causing hypertension, as this drug has been found to be inactivated by one passage through the liver.<sup>19</sup> The vasoconstriction produced is probably temporary, which may account for the re-bleeding that has been reported.<sup>20</sup>

The mortality rate for "medical management"

in massive bleeding from duodenal ulcers is unknown, as most of the medical failures are referred for a surgical procedure. Retrospective studies indicate the mortality rate to be in the area of 15% to 25%.<sup>5</sup> Well controlled and statistically valid studies show that operative methods are better than non-operative in massive hemorrhage, especially in selected cases.<sup>21,22</sup>

### **Management of Moderate Bleeding**

While these patients are hemodynamically stable, they must be carefully observed as sudden massive hemorrhage can occur at any time. Most of these patients are admitted with melena and often are without pain or hematemesis. In undiagnosed cases a nasogastric tube is passed to determine if fresh blood is present and to test the acid levels. This tube will rarely reactivate bleeding if it is inserted carefully. The tube is removed if active bleeding has stopped and if the patient is not nauseated.

Hourly feeding should be given, alternating milk and cream and other soft foods, with antacids. Anticholinergics are often given every four hours to diminish gastric secretion. However, some authors feel that anticholinergics cause pylorospasm and the delayed emptying that results will adversely affect the treatment. Sedatives are given as needed.

The nature of the food ingested is probably less important than being sure that something is present to neutralize the digestive effect of the gastric and duodenal juices.

In the absence of a Levine tube, a central venous line and a urinary catheter, it is imperative that vital signs be monitored hourly. During the first 48 hours hematocrit levels should be determined every eight hours. Serum gastrin levels by immunoassay have been used diagnostically in some institutions and may be useful in predicting the type of treatment needed or assessing the effectiveness of a method of treatment.

In all cases a barium meal should be ordered as soon as possible in order to establish the diagnosis. Patients with known liver disease and esophageal varices may be bleeding from peptic ulcers rather than the varices. Esophagogastroscopy should be ordered when the barium meal is not diagnostic. A coagulation profile and liver function studies should be part of the routine management. A search must be made for drug sensitivities and the history of taking ulcerogenic drugs must be determined. Aspirin, butazolidin, tobacco, alcohol, coffee, steroids and other known gastric irritants should be eliminated.

## **Indications for Emergency Operation in Massive Bleeding from Duodenal Peptic Ulcers:**

1. Inability to maintain vital signs while replacing blood. The rate of hemorrhage exceeds the rate of blood replacement.<sup>2</sup>
2. Continued bleeding after 48 hours of medical management.<sup>5</sup>
3. Fifteen hundred cc. of blood replacement in any 24-hour period or one unit every eight hours.<sup>2,7</sup>
4. Recurrent hemorrhage after cessation of bleeding. The second hemorrhage is usually more severe than the first.<sup>2,7,23</sup>
5. Concomitant obstruction or perforation.<sup>5</sup>
6. Patients 50 years or older should be operated upon after three transfusions. Older patients, especially if accompanied by a general medical disorder, are less able to compensate for the blood loss.<sup>2,9,24-28</sup>

## **Indications for Elective Surgical Procedures in Moderate Hemorrhages**

A moderate hemorrhage is defined as a bleed that requires less than three pints of blood to correct the vital signs, and at no time does the patient exhibit the signs or symptoms of shock. The indications for operation that we use are:

1. Two moderate bleeds during any one hospitalization.
2. Three moderate bleeds that require blood or plasma expanders.
3. Two moderate bleeds in patients that are 50 or older.
4. Bleeding while on medical management.

It is well established that if the bleeding can be stopped by medical management and the surgery performed electively, the patient will have a much greater chance for survival.<sup>5,27,29</sup>

Recently, we have tended to relax the indications for operations in patients with moderate bleeding. With an operative procedure that has a low mortality and morbidity (vagotomy and wide pyloroplasty) we feel that better control of the ulcer disease can be afforded by surgical rather than medical management.<sup>30</sup>

## **Mortality Rates in Operations for Bleeding Ulcers**

The mortality rate in *emergency* operations for massive bleeding from peptic ulcer disease is much higher than in *elective* operations.<sup>13,29,31</sup> Mortality rates for emergency operations vary from 10% to 32% while the rate for non-emer-

gency or early elective operations is 1% to 7%. An average of several series reveals 22% deaths in emergency operations and 3% deaths in elective operations. The death rate is higher in older patients, those with concomitant serious illnesses, those that require multiple transfusions, and in re-bleeders. Death rates are higher in municipal hospitals than in private practice hospitals due to an older age group, late treatment, and more serious concomitant illnesses. <sup>1-5,7,8,10,13,24-29,31-35</sup>

## **Selection of the Surgical Procedures in Massive Hemorrhage**

Almost all surgeons agree that vagotomy and oversewing of the bleeding point should be performed when operating for a bleeding duodenal ulcer. Controversy exists as to whether these procedures should be accompanied by antrectomy or pyloroplasty. Recently Crook, et al, has averaged many series and has concluded that the mortality rate in vagotomy, ligation of the bleeder, and resection is about 20% while vagotomy, ligation of the bleeder, and pyloroplasty is about 10%.<sup>3,5,7,27</sup> When multiple bleeding sites are present some surgeons believe a resection should be carried out<sup>13,35</sup> while other studies show that bleeding can be controlled by vagotomy and pyloroplasty.<sup>36</sup> Giant ulcers have a greater tendency to re-bleed and may need to be resected.<sup>2</sup>

The best operation for the massively bleeding duodenal ulcer is one that provides immediate control of the bleeding vessel and control of the ulcer diathesis with the lowest operative mortality rate.<sup>2</sup> Ligation of the bleeding vessels, pyloroplasty, and vagotomy achieves this result.<sup>4,10,12,23,26-28,34,37</sup>

## **The Operative Procedure**

A midline incision is made from the xiphoid to the umbilicus. A truncal vagotomy is performed (unless severe uncontrollable hemorrhage would dictate attacking the ulcer bleeding first) as a selective vagotomy is more time consuming. We feel that performing the vagotomy first reduces contamination of the subphrenic space and reduces the handling of a newly sutured gastroduodenotomy.

A pre-pyloric gastrotomy is performed. This allows the operator to see if the bleeding is gastric or duodenal (if bleeding is active) as well as to palpate the intact pylorus for stenosis. The examining finger can then palpate the antrum, pylorus and duodenum for ulcerations. The pyloric sphincter and duodenum are incised over the avascular anterior aspect making a 7

mm. gastroduodenotomy. A suction tip is used to clear the blood and carefully locate the bleeding site. The bleeding area is oversewn with two 2.0atraumatic non-absorbable sutures, one above and one below the vertical pancreaticoduodenal artery but not tied down. If the vessel is not bleeding it should be sponged to wipe away the clots until bleeding occurs. Thus, when the hemostatic sutures are tied down it can be determined that hemostasis is complete. A small suction tip again is used to keep the field clear of blood so that the bleeding vessel is carefully identified and sutured. When you find an indurated ulcer base, use a small heavy curved needle as a thin needle may break. The stomach is then irrigated with sterile saline to see if a second bleeder is present.<sup>27</sup> If there is continued bleeding from the stomach, a separate, large gastrostomy is made. A second bleeder is not uncommon and all the bleeding points should be localized and oversewn. A "blind" gastrectomy is to be avoided.<sup>38</sup>

If no additional bleeding point is found, mucosa over the back wall of the pylorus is opened, the pyloric muscle transected, and the mucosa and submucosa closed with interrupted 3.0 non-absorbable suture according to the Hines modification of the Heineke-Mikulicz pyloroplasty.<sup>39</sup> The anterior wall is closed in a single layer according to the Weinberg modification of the Heineke-Mikulicz pyloroplasty.<sup>27</sup> The double transection of the pylorus destroys the sphincter action of this circular muscle and provides better gastric emptying.<sup>39</sup>

If the ulcer bleeding is attacked first the vagotomy is performed after changing gowns, gloves and instruments. It must be pointed out that after ligating the bleeding point, you must continue and do a drainage procedure and vagotomy. Failure to complete all three procedures will result in a prohibitive recurrence rate.<sup>2,27</sup> The vagotomy temporarily reduces the gastric blood flow as well as to control the ulcer diaisis.<sup>40,41</sup>

The post-operative period requires careful monitoring to maintain blood and fluid balance and to be alert for continued or re-bleeding. We use a nasogastric tube for the first 24-48 hours. Early removal of the nasogastric tube reduces pulmonary problems, makes for easier ambulation and lessens the fluid and electrolyte problems.<sup>23</sup> The wide pyloroplasty lessens the possibility of post-operative gastric retention. We have recently performed vagotomy, double pyloroplasty and ligation of the bleeding point in 26 patients with

bleeding duodenal ulcers. There has been no serious complication, no deaths, and no recurrence of bleeding.

A review of the literature reveals that there is a recurrence of bleeding in eight to 30% of patients that have had surgical procedures for bleeding duodenal ulcers.<sup>2,10,12,42,43</sup> After subtotal gastrectomy, series vary from eight to 33%.<sup>32,43,44</sup> Vagotomy and antrectomy have a recurrence of bleeding in six to 15% with a recently compiled series averaging 10%.<sup>7</sup> Vagotomy and pyloroplasty have recurrent bleeding in five to 26% of the cases, with the average recurrence at about 15%.<sup>1,4,7,26,44,45</sup> Of the recurrent bleeders, most are brought under control on medical management but about half of the massive re-bleeders will need to have further surgery.<sup>1,4,10,12,26,30,32,34,43-45</sup>

It is apparent that the recurrence of bleeding is often related to inaccurate ligation of the bleeding vessel, incomplete vagotomy, and gastric stasis. With complete vagotomy, newer outlet procedures, and better vessel ligation all of these factors are greatly reduced. At this time we feel that the slightly higher recurrence rate following vagotomy and a drainage procedure (as compared to vagotomy and gastric resection) is justified by a much lower mortality and morbidity rate and is followed by less untoward post-operative sequelae.<sup>1,2,46,47</sup>

Recently, attention has been directed to reducing recurrent bleeding by eliminating certain gastroduodenal irritants. Alcohol, tobacco, caffeine, butazolidin, steroids, aspirin and other known ulcerogenic medications and drugs are eliminated. This should help reduce the recurrences following any procedure. Long-term recurrence rates after prospective studies have tended to show an increased recurrence rate after vagotomy and drainage as compared to vagotomy and antrectomy.<sup>46-48</sup> These studies included all aspects of ulcer disease and would tend to show that under ideal conditions the mortality and morbidity rates are about the same in both procedures and that the increased recurrence rates are related to a larger number of positive Hollander tests after vagotomy and pyloroplasty.<sup>47</sup> In spite of these impressive studies most authors feel that in patients with bleeding duodenal ulcers, vagotomy, ligation of the bleeding vessel, and pyloroplasty affords the best protection with the lowest mortality rate.

## Summary

Bleeding from duodenal peptic ulcer disease

carries a formidable mortality rate. This mortality rate is higher in older patients, those who are admitted late in their disease, those with serious concomitant medical illnesses, and those patients that have recurrent bleeding after cessation on medical management. A large number of deaths are related to poor perfusion of the vital organs resulting in strokes, respiratory failure, myocardial infarction, and renal failure. Adequate perfusion must be maintained at all times, especially in patients with pre-existing diseases. A sound case can be made for early surgical intervention in massive bleeding from peptic ulcer disease, especially in patients over 50 years of age. Patients should have emergency operation to stop the bleeding if they have bled three pints in one day or seven pints in three days.

Early elective operation after cessation of massive bleeding appears to offer the best protection for the patient with bleeding duodenal ulcers.

The authors feel that vagotomy, ligation of the bleeding point, and a widely patent pyloroplasty is the best treatment in both acute massive bleeding and as an elective operation for intermittent moderate bleeding. Patients with multiple bleeding points, giant ulcers, and those with extremely high acid levels are best treated by vagotomy, ligation of bleeding points and partial gastrectomy. ▶

#### References

A complete bibliography for "The Bleeding Duodenal Ulcer" may be obtained by writing to the *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago 60601.

## Personal History of Paget's Disease

(Continued from page 179)

after 8 days because I was having a recurrence of the old formications and my reading was again becoming distressful.

My headaches, however, continued. In November, 1952, after eating improper food I developed a severe gastroenteritis with pronounced dehydration. At this time I was struck by the absence of headache, and then reasoned that relief of headache resulted from the dehydration. I could then recall specific instances when headache occurred or was aggravated by high sodium intake. As I had read, many years before, that the blood

volume in Paget's of the skull might be increased, and knowing that this was shown recently to be true in my case, I decided to test the effect of a minimal sodium intake. When I reached an intake of less than 500 mg. sodium a day, the response was very gratifying. Headaches have been absent since. The dullness, poor comprehension and deficient memory all cleared up. I became more alert, was again able to study, and to take a deep interest in life and medicine which I have enjoyed the past 20 years.

#### Conclusion

Despite the occurrence of Paget's in adults being reported up to 3%, only a small portion of these have extensive Paget's with much disability. It is difficult to state in my case how much of my symptoms were due to Paget's and how much to the related problems. While it is stated that the increased vascularity or possible neurologic conditions produce the headaches, I believe I have shown that my headaches are due to increases in the basic high blood volume, and that they are relieved or prevented by a diet with minimal sodium intake.

Many of my skeletal distresses are evidently due to a concurrence of Paget's, gout and possibly degenerative osteoarthritis.

Even though the generalized neuritides and the eye distresses are relieved by probenecid, I have been unable to find any mention or explanation for these phenomena.

For many years I have had wide fluctuations in the alkaline phosphatase values, and I noticed the big increases coincided with periods of increased bone distresses.

I am aware of all the recent work with new medications, but I was fortunate to solve my problems when there was nothing therapeutic known or investigated, 21 years ago. ▶

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# Primary Ovarian Pregnancy

BY WILLIAM VULGARIS, M.D. AND WALTER REICH, M.D./CHICAGO

Mercerus, in 1641, was the first to suggest the possibility of ovarian pregnancy, but the first case was reported by Saint Maurice de Perigod in France. The first accurate clinical and histological study was made by Tussenbroek of Brussels in 1899.

Ovarian pregnancies are classified as primary and secondary, with primary ovarian pregnancy being our subject in this paper.

It has been stated repeatedly in almost every paper which deals with the present subject that primary ovarian pregnancy occurs once in every 25,000 - 40,000 cases, and in 0.7% or 0.4% of ectopic pregnancies, although Tabor and Crossett go as high as 2.7%. Eckenson goes as low as 0.29%.

Titus claims that many "chocolate cysts" of the ovary were in reality ovarian pregnancies, but couldn't be recognized because of early rupture of the sac, or because of degenerative changes occurring in pregnancy.

In a review of the literature, we have collected 211 reported authentic cases of primary ovarian pregnancy, including our own cases.

Over a ten year period, in our hospital, out of a total of 13,320 deliveries, only one case of primary ovarian pregnancy has been observed, which we will discuss later in detail.



WILLIAM VULGARIS, M.D., is a senior attending staff member of Gront Hospital, Chicago. Dr. Vulgaris previously was an associate at Fontus Clinic, Cook County Hospital. He is a graduate of National and Kapodistria University, Athens, Greece.



WALTER REICH, M.D., maintains a private practice in gynecology and is consultant of Cook County, Oak Forest and Grant Hospitals, Chicago. A graduate of the University of Illinois College of Medicine, he was a Professor of Gynecology at Cook County Graduate School of Medicine, 1934-1970. He is the co-author of *Practical Gynecology and Pitfalls in Gynecology Diagnosis and Surgery*.

To classify a case of primary ovarian pregnancy as such, Spiegelberg in 1879 recorded his criteria for recognition of the abnormality:

1. The tube on the affected side must be intact.
2. The fetal sac must occupy the position of the ovary.
3. The pregnancy must be connected to the uterus by the utero-ovarian ligament.
4. There must be ovarian tissue in the sac wall.

These rules are classic and have been unquestionably accepted and followed. Williams adds to the above four rules that unquestionable ovarian tissue must be found at several places in the wall of the sac at some distance from each other.

Miller, for the intrafollicular type of primary ovarian pregnancy, states that a section through the base of the ovum must reveal either a fresh corpus encircling the ovum, or it must disclose the ovum lying close to the corpus, which must show signs that the ovum has passed through it.

## Etiology of Primary Ovarian Pregnancy

### Mechanism of Ovarian Pregnancy

Within recent years, Veit's view has been accepted that implantation is not necessarily within the follicle from which the ovum was discharged. It is true that after its discharge the ovum may be fertilised and then take root in the follicle or corpus luteum (intrafollicular implantation), but these are soon penetrated by the trophoblast which pushes into deeper ovarian structure (juxtapositional implantation). However, the most common mechanism as Meyer asserts, is through cortical implantation of the egg. A logical explanation for this might be the great frequency with which endometrium is found in the ovary, and the probability, according to many, that this is due to the differentiating potency of the germinal epithelium. In many cases, however, there is much difficulty in establishing the meth-

od of implantation.

Tubal pregnancy ruptures earlier than ovarian. Ovarian pregnancy terminates, usually, through early rupture, but may advance to full term, and the fetus succumb after a spurious labor, if operation is not carried out or it ends in lithopedion formation. Approximately 75% are terminated in the first trimester; 12½% in second trimester; and 12½% in the third.

*Intrafollicular—Ovum implanted in the follicle.*

Leopold believes that the ovum which is impeded in its progress by a narrow tortuous channel, is held in its position while the sperm penetrates and fertilizes the ovum. Others believe that the force of escaping intrafollicular fluid is not great enough to push the ovum out of the follicle covered by pathologic tunica albuginæ. Another explanation is that a small blood clot obstructs the ostium but this does not explain the sperm penetration. Still another explanation is that the ovum is discharged in the follicle and is not washed out by escaping fluid.

*Interstitial:*

The ovum is implanted in the interstitial tissue of the ovary.

*Peripheral:*

*Superficial*—enidation occurs on the surface or just under it. The ovum burrows deeper or extends outward. This happens when the capsule is thickened due to old healed disease, ovarian endometriosis, peritoneal adhesion or cystic degeneration of the follicle before rupture.

*Suprafollicular*—the ovum is an interstitial implantation, in which even if the ovum ruptures from the follicle it remains at the point of rupture.

The most common types are the intrafollicular and the interstitial. Only 10% are extrafollicular. Some believe that the extrafollicular starts as intrafollicular. Barda reported a case which he believes was due to implantation in embryonic muellerian duct tissue.

Shettles, in 1957, believed that primary ovarian pregnancy in the human is parthenogenetic in origin. This was investigated by David J. B. Ashley, by determining the sex of offspring of 12 ovarian pregnancies. Several were found to have male nuclear sex and five were of female nuclear sex. So fertilisation precedes implantation of the zygote.

*Secondary Ovarian Pregnancy:*

Secondary ovarian pregnancy is dislodged tubal pregnancy due to tubal obstruction from healed diseased tube, peritubal adhesions, and functional changes in the tunica albuginæ.

Novak claims that the ovum does not necessarily implant in the follicle from which it was discharged. F. M. Lyle and O. O. Christianson described a case of primary ovarian pregnancy 11 years after vaginal hysterectomy, complicated postoperatively by fistula of the vaginal vault. Hydatiform mole and eclampsia have been reported accompanying primary ovarian pregnancy. Primary ovarian pregnancy implanted in endometrial cyst of the ovary was reported in two cases by Baten-Heinc and by B. Bercouici, et al. Repeat primary ovarian pregnancy was reported by John T. Pewters (1953). Simultaneous intrauterine pregnancy and primary ovarian pregnancy (Herman W. Rannels, 1953) also was reported.

## Symptomatology

*Age:* The range was 18-41 years old.

*Race:* There were 13 patients of the white race; 4 Negro, 5 Chinese, 1 Indian, 1 Malay, 1 case of Spanish American descent and another 6 cases of unknown race, because the race was not recorded.

*Parity:* Was from 0 to 12.

*Missed period:* Missed period ranged from 1 - 44 weeks, with most of cases around: (a) the 8th week, and (b) the 4th week.

*Abdominal pain.* Generalized abdominal pain was found in 26 patients of which 1 patient complained also of pain in the rectum, nine of low abdominal pain and one of abdominal cramps. Three patients complained of LLQ quadrant localized pain and nine patients of pain in the Rt lower quadrant, 22 had generalized abdominal pain. One patient complained of periumbilical pain and one patient complained of generalized pain which spread to the lower back. There were three patients without abdominal pain. Ten patients complained of fainting, while vomiting and nausea was experienced by 26 patients.

*Morning sickness:* one patient.

*Breast engorgement:* five patients.

*Shoulder pain:* twenty patients.

*Vaginal bleeding:* was reported by thirty seven patients.

The physical examination revealed:

*Abdominal tenderness at hypogastrum:* 19 patients

*Generalized tenderness* 26 patients

Right lower quadrant: eight patients

Left lower quadrant: two patients.

Bil.: seven patients.

No abdominal tenderness: twenty patients.

Rebound tenderness: twelve patients.

*Rigidity:* Generalized: 11 cases

Lower abdomen: 3 cases

Distention: 3 cases

*Pelvic examination:* Cervix was blue: 1 patient

Cervix was soft: 10 patients

*Pain on cervical movement:* 12

*Blood noticed from cervical canal:* 11 cases

*Corpus:* One case the corpus was 16 cent. above the symphysis. FHT were present. This patient delivered normally an 8 lb. 2 oz. baby boy at term. At sterilization operation a week later a 7 cent. ovarian cyst was removed which proved to be an ovarian pregnancy. 1 case had some enlargement of the uterus.

*Temperature:* The highest temperature was 99.4° and the

lowest 96.4°:

Blood pressure: 58/40, 90/40 - 144/65.

Pulse: from 68 to 126 per minute.

Shock: 10.

Respirations: from 18 to 32 respirations p.m.

Pregnancy test: Positive—6 cases; Negative—2 cases.

Urine: Negative in 4 cases.

Hemotocrit: 26% - 40.7%

Hemoglobin: from 5.2 GM - 13.7 GM

RBC's from 2,040,000 - 4,570,000

WBC's from 5,300 - 27,500

Differential: polys 52% - 92%

#### Preoperative Diagnosis:

1. Ovarian cyst (ruptured): 2 cases
2. Corpus luteum: 1 case
3. Threatened abortion: 2 cases
4. Incomplete abortion: 1 case
5. Intra-uterine pregnancy: 1 case
6. Ectopic pregnancies: 31, of which 13 were diagnosed ruptured.
7. Appendicitis perforated complicating 2nd month pregnancy: 1 case
8. Acute appendicitis: 2 cases
9. Impacted hemorrhagic cyst with intra-uterine pregnancy: 1 case
10. Twisted ovarian cyst: 2 cases
11. Endometrioma of ovary: 2 cases
12. Hydro-salpinx: 1 case
13. Abdominal pregnancy 44 weeks (postmaturity): 1 case and another case at 42 weeks.
14. Metrorrhagia - endometriosis.

Diagnostic procedures: Colposcopy was performed on 11 cases. Blood obtained in 10 of the cases.

Dilatation and Curettage was performed only on 7 cases.

1 case showed normal curettings.

3 cases showed secretary endometrium.

2 cases showed desidual reaction.

1 case no curettings obtained.

1 case showed physiologic hyperplasia of endometrium, proliferative phase. On opening the abdomen blood was found in 18 cases in the abdominal cavity, which averaged from 0 — 2000 cc.

#### Operations:

1. Salpingo-oophorectomy: 16 cases
2. Salpingo-oophorectomy-appendectomy: 1 case
3. Partial resection of ovary: left: 1 case, right: 4 cases
4. Total abdominal hysterectomy and bil. salpingo-oophorectomy: 2 cases, solid mass extracted: 1 case
5. Excision of cyst of ovary: 9 cases
6. Oophorectomy: 7 cases.
7. Case of supervaginal hysterectomy with bil. salpingo-oophorectomy (Rt. ovarian pregnancy, endometriosis, fibromyomata).
8. Case of vaginal delivery of full term infant.  
One week later in the process of sterilization operation a Rt ovarian cyst was found, which was resected and proved to be primary ovarian pregnancy.

#### Postoperative Diagnosis: Pathology

1. Left ovarian pregnancy: 20, of which 2 contained embryo. Ruptured: 2 cases
2. Right ovarian pregnancy: 37 of which contained embryo. Ruptured were 7 stated cases.
3. One case contained embryo, but the side was not reported.

Note: One case of the right ovarian pregnancy was associated with endometriosis and fibromyomata of the uterus. One Rt ovarian pregnancy was twin.

4. One right ovarian pregnancy was associated with intra-uterine pregnancy, which was complicated by toxemia of pregnancy and intra-uterine pregnancy, went to term and delivered an 8 lb. 2 oz. baby boy. The ovarian pregnancy was found one week later, when sterilization was performed.
5. There is one case of right ovarian pregnancy which was operated and a right salpingo-oophorectomy was done. Twenty-six months later, the patient developed a left ovarian pregnancy.

There were four D and C's stated, of which two showed secretory cells and another two decidual.

Mortality: All cases of the present series survived the operation.

## Case History

A 24-year-old white married woman was admitted to the hospital on 1/22/61, complaining chiefly of some vaginal bleeding, and slight tenderness at LLQ and lower back. She was nauseated and had engorged breasts.

Past History: Tonsillectomy in childhood and infectious mononucleosis.

Family History: An older sister was operated by the author for left tubal pregnancy in 1953.

Menstrual History: Menarche was at the age of 11, with subsequent menstruation at intervals of 28 days, and duration of flow of four days. She was Para II (two full term pregnancies) and one miscarriage at the 3rd month in 1959.

Present Illness: The last menstrual period was on Nov. 18, 1960. In December she missed her monthly period. January 3, 1961, she started a menstrual period which continued until January 10, 1961. Next day the patient had minimal amount of vaginal spotting. Pain in LLQ became stronger. During this period she passed many clots and had cramps the first two days. This bleeding recurred on January 13, 1961, with smaller clots. It lasted until January 19, 1961. At this time bleeding stopped completely.

Physical Examination: The patient was in no acute distress, comfortable and had a pulse of 80 per minute, blood pressure 130/80 and respiration 20 per minute. The breasts were engorged. The heart was normal in size and no murmurs were present. The abdomen was soft, tender at LLQ. The liver was normal on palpation. The spleen was not palpable. No abdominal rigidity or rebound tenderness was present. On pelvic examination, the external genitalia appeared normal. The cervix felt hard and was in the middle line. The external os was that of a multiparous female with no blood present. There was a tender mass at left adnexa.

The right adnexa was normal on palpation. The corpus was of normal size. There were no masses in the cul-de-sac.

*Laboratory Findings:* Hematocrit was 41% WBC 13,800. The differential was polymorphonuclear cells 52%, lymphocytes 43%, monocytes 1%, eosinophiles 4%, blood glucose 71 mg, Urea nitrogen 8, Kahn was negative.

*Urine:* Ph 6.0, glucose zero, protein zero. Ketone bodies were negative. Leukocytes 1-4, erythrocytes zero. A few bacteria were visible (voided). Pregnancy test was positive. Diagnosis was that of left ectopic pregnancy.

"Dilatation and curettage" was performed and a moderate amount of material was obtained. Colpocectesis was done and there was old blood in the peritoneal cavity. An abdominal incision was made. A mass on the left side was found, which was old blood clot about the size of an English walnut, plus the ovary and the tube. These three structures were adherent to the sigmoid. The operative procedure was a separation of adhesions, a left salpingo-oophorectomy was performed.

*Pathology Report:* "Specimen of left tube and ovary." Gross Diagnosis: Recent hemorrhage of ovary. The fresh specimen consisted of a uterine tube and attached its corresponding ovary. The specimen had been previously opened and some blood clots were seen closely attached.

The uterine tube measured 5 cm., it had a bright red exterior with a tortuous appearance. On section, the cut surface was not remarkable. The fimbria was present and between it and the ovary was a blood clot. The ovary presented an oval shape with a tannish-gray exterior. On section, the cut surface of the ovary was shiny, bright red in color and presents the end of a small blood clot attached. Representative sections were imbedded.

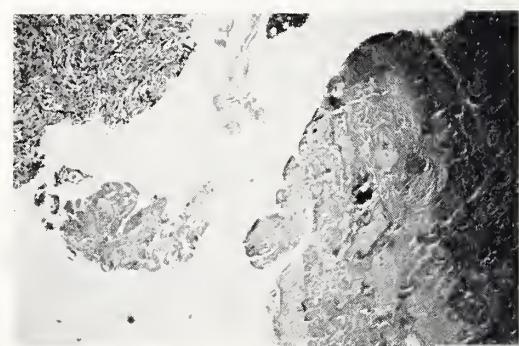
*Specimen of I-Endometrial scrapings II-Cervical polyp:* Gross-II-The specimen in formalin consisted of several small soft fragments of reddish-tan tissue occupying a volume of about 2 ml. imbedded in toto. III-The specimen in formalin consisted of a few short irregular fragments of grayish-tan tissue occupying a volume of about 0.6 ml. No definite polyp could be identified. Imbedded in toto.

*Microscopic I*-Sections of the entire specimen showed fragments of endometrium containing moderate number of glands. The glands were lined by tall columnar epithelium with slight tendency to stratify with empty small lumina. No subnuclear vacuoles were seen and the sur-

rounding stroma reveal beginning edema and congestion. *II*-Sections of the entire specimen revealed similar tissue as seen above. Nowhere in the entire sections was a polyp seen.

*Diagnosis I- and II*-Physiological hyperplasia of endometrium, proliferative phase.

Note: The hyperplasia seen in I and II was like that seen on the 14th day of a 28 day menstrual cycle. (See Figures)



Microscopic sections showed ovary, somewhat fibrotic and containing numerous corpus albicans and mature follicles mingled with some

(Continued on page 226)

# Rehabilitation of the Patient With Chronic Low Back Pain

BY AARON M. ROSENTHAL, M.D./CHICAGO

Patients with chronic pain in the low back commonly are seen by most physicians.<sup>1</sup> Although the cause for the pain may not be readily apparent, it is essential that a detailed diagnostic work-up be performed. In many instances this will illuminate the cause and make it possible to institute a course of treatment which is curative.

However, there are some instances in which the cause remains obscure despite a complete diagnostic survey. In these cases, symptomatic therapy may not be very successful. Indeed, some patients continue to complain of low back pain despite the institution of all sorts of treatment, including the use of analgesics, local heat, local cold, corticosteroid therapy, pelvic traction, laminectomy and even spinal fusion.

How then should these hard core cases be treated in order to relieve their backache? It is my opinion that we need to treat the patient's psychological, social and vocational problems as well as his physical pain if we are to achieve a degree of success. Directing our therapy exclusively to the back will not help many of these hard core cases.

A patient who has been hampered by chronic low back disability is often unable to work to support himself and his family. This creates a financial problem which may require the patient to seek help from public welfare or from workman's compensation. In some circumstances, the patient's spouse may be forced to seek employment and this may require a reversal of roles in the family. The male patient may be obliged to become the homemaker and this sometimes produces psychological effects.

It is evident, therefore, that many patients with low back pain also suffer from psychological,

social and vocational consequences. A successful outcome may require probing in these areas and may require skillful counseling. The concerned physician must understand his patient's life style and deal with it to reach successful resolution of the backache.

In some instances it may be best for the patient to be hospitalized to enable the physician to perform a careful, complete diagnostic evaluation. It should be emphasized that history taking should be sufficiently detailed to determine whether there are psychological elements which have contributed to the persistence of back pain. In addition, the possibility of secondary economic gain should be explored. In certain instances a man with chronic disabling low back pain can receive disability benefits which provide him with more tax free dollars than he could earn as a productive worker.

A careful physical examination should follow the history taking in order to determine whether there is objective evidence of local musculoskeletal pathology. The absence of such evidence may suggest the importance of psychological factors in the production of back symptoms.<sup>2</sup>

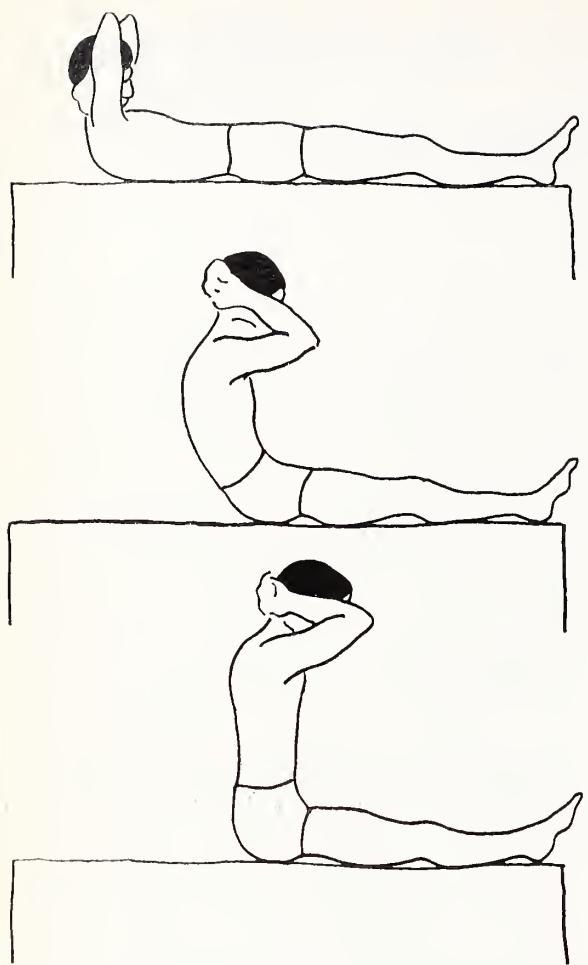
Laboratory confirmation logically follows. X-ray of the lumbosacral spine and electromyography should be performed routinely to determine if there is bone, joint disease, nerve root compression or intrinsic myopathy. Additional studies such as pantopaque myelography should be performed if one suspects intervertebral disc protrusion or spinal cord tumor.

It must be emphasized that if the results of these studies are negative, the physician should continue his scrupulous survey.<sup>3</sup> Additional information can be obtained from psychological testing, psychiatric consultation or from social service evaluation. This is particularly true for those patients in whom psychological factors are suspected to be important in the persistence of the backache.

When all of this information has been accumulated, the physician should review and evaluate it in order to institute a reasonable course of management. The treatment plan



AARON M. ROSENTHAL, M.D., is Director, Physical Medicine and Rehabilitation at Lurie Memorial (formerly Fax River) and Weiss Memorial Hospitals, Chicago. A graduate of Jefferson Medical College, Philadelphia, Dr. Rosenthal is active on the ISMS Council on Social and Medical Services.



#### Williams Exercise Routine

should work if it takes into account all of the factors which produced the symptoms. The thrust of the program is multifaceted in order to meet the patient's needs. The basic program should include back exercise, extrinsic back support, psychological counseling and vocational evaluation.

The simplest, most effective method for exercising the back is by means of the Williams exercise routine (see figures). The exercise begins with the patient lying flat in the supine position. He keeps his pelvis flat against the table surface and then raises his head, neck and trunk to a sitting position without the help of his hands. This maneuver is performed ten times at one session. The patient repeats these ten repetitions two or three times per day. As a result, he will strengthen his abdominal muscles and will stretch his erector spinae muscles.

In addition, the patient is taught to bend to pick up objects by maintaining a straight spine and by flexing at the knees and hips.

This puts the stress on the bony components which can withstand them rather than on the soft tissues which cannot. The normal spine can withstand a great deal of compressive force without injury whereas shear force stresses are poorly tolerated.

In addition to the exercise routine, a back brace or corset should be worn when not exercising to give the patient extrinsic support. This support is indicated especially for those patients with recurrent, disabling back pain. A variety of corsets and braces are available but we prefer to prescribe a Hoke corset or a Knight Spinal back brace. Both of these give high back support by means of paravertebral stays. It must be mentioned that women accept corseting more readily than men. Patients with severe back disability do better with a Knight brace than with a corset.

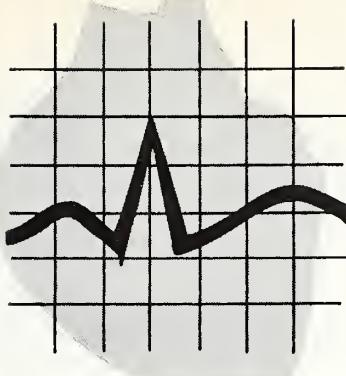
For about three months the back support should be worn at all times except during exercise, bathing and sleep. If the patient does well, then he should be weaned from the device gradually. However, it is important to note that whenever the patient anticipates that he will engage in a stressful activity he should wear the support.

Concurrently with the prescription of exercise and back support, there should also be psychological counseling. Opportunities should be made available for patients to discuss their problems, which may be producing the back pain, to develop insight about this. As a consequence, the back pain may disappear. Such a happy outcome, of course, may take some time but this does happen as a result of psychotherapy. Sometimes group therapy may be beneficial, particularly if the group is composed of patients with similar symptoms.

For rehabilitation to become complete and to remain effective, the patient should be able to return to productive work. Vocational evaluation and vocational counseling may be useful in order to achieve this goal. Most people who need to earn a living can perform some occupational task even with chronic low back pain. The trick is to match skills, interest and patient performance with the local labor market.

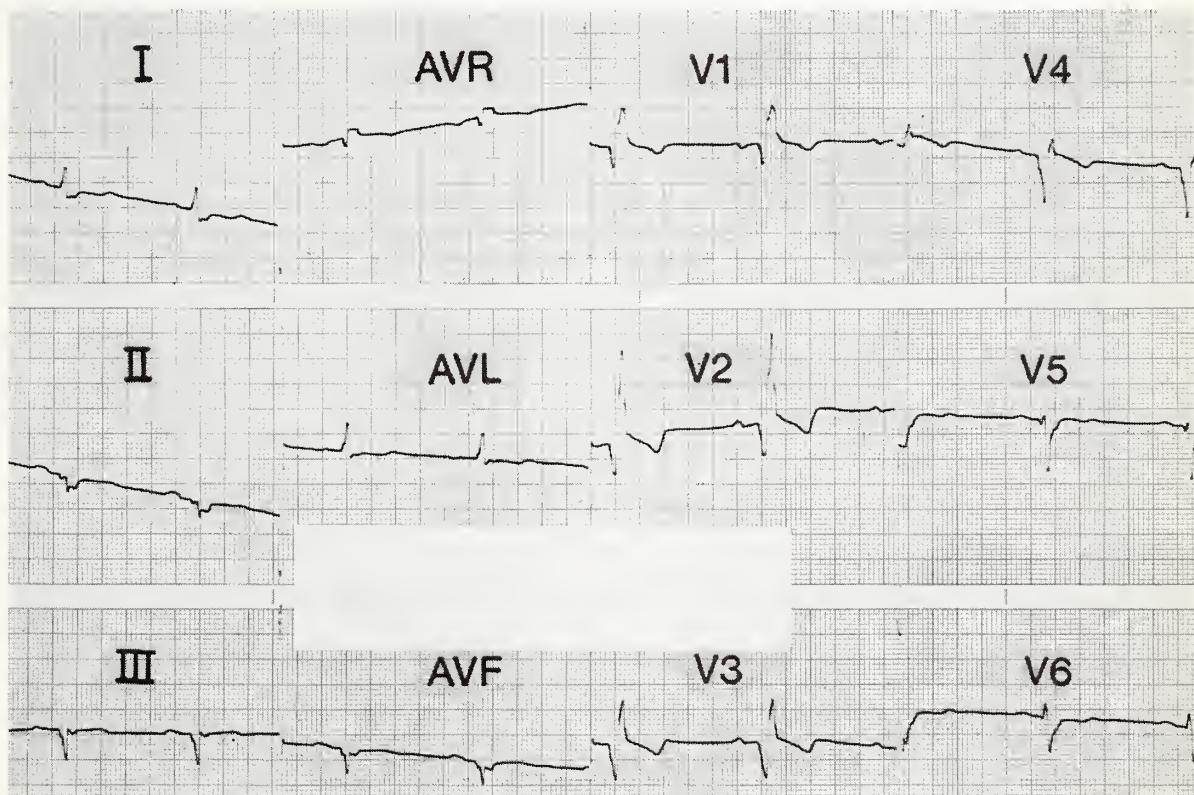
Sometimes, a graduated program can be started in which the patient begins in a sheltered setting, moves on to part-time employment and may even be able to reach full-time work in due time. In order to work, patients need to feel comfortable. They need to find out that carefully selected work will not aggravate their backache. Employers and workmen's compensation

*(Continued on page 223)*



# ekg of the month

JOHN R. TOBIN, M.D., M.S., RIMGAUDAS, NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
JAMES V. TALANO, M.D., SARAH JOHNSON, M.D. and  
ROLF M. GUNNAR, M.D., M.S./Section of Cardiology,  
Loyola University Stritch School of Medicine



A 63-year-old man presents to the office for evaluation of recurrent nagging epigastric distress. It awakens him from sleep in the early morning hours. It seems to be relieved by milk, food, or antacid therapy. He is afraid he has developed an ulcer. Fourteen months earlier he sustained a myocardial infarction elsewhere for which he was in the hospital for six weeks. An upper G.I. series shows an ulcer crater in the duodenum. The ECG is presented.

Questions:

**1. The 12 lead ECG shows:**

- A. An anteroseptal myocardial infarction.
- B. Complete right bundle branch block.
- C. Left axis deviation or left anterior hemiblock.
- D. Complete left bundle branch block.
- E. First degree AV block.

**2. The following statements are true:**

- A. This patient has severe coronary artery disease.

- B. This patient might be in danger of complete heart block.
- C. A pacemaker should be implanted.
- D. A recording of the patient's bundle electrogram could be helpful from a prognostic viewpoint.
- E. A careful review of the records of the hospitalization for myocardial infarction should be done.

(Answers on page 222)



# membership forum

## One Response on Chiropractic Treatment

*Ed. note.: Recently the IMJ carried an article on chiropractic (April, 1974, Vol. 145, No. 4, pages 326-332) and asked for comment from the membership. Several items have been submitted. One of the most illustrative is that of a child being treated for epilepsy. The workup is published here so the membership might be alerted to the methodology being followed by chiropractic. Confidentiality of all parties, of course, is protected and thus no physical data or other identification is included. Fortunately the child was sent to one of the members before the "work" was started or the "savings" realized. The patient is now seizure-free. But "practitioner" in this case is the only "doctor" in the small town.*

Dr. \_\_\_\_\_  
Chiropractor  
\_\_\_\_\_, Illinois

### CHIROPRACTIC EXAMINATION AND RECOMMENDATIONS

**Confidential Report** -----

**Date** -----

In order to make the facts of this report quite clear, a short explanation of the basic principle of the chiropractic approach to better health is first necessary.

The doctor of chiropractic works directly and indirectly with both the spinal column and nervous system. As every function in your body is under the influence of the nervous system, disturbances in spinal balance and nervous equilibrium will have important effects.

Chiropractic has special methods for finding and correcting these disturbances that can effect nerve function in many parts of the body.

As a result of our examination and correlation of findings, it is considered that your case be treated with chiropractic methods. It is recommended that you give this report careful study and consideration.

Yours sincerely,

\_\_\_\_\_, D.C.

**Chief Complaint:** Epilepsy

**Secondary Complaints:** Nervousness, convulsions, poor appetite, colds, nasal obstruction, allergy, chills, headaches, itching.

**Examinations Made:** Personal consultation and interview. Preliminary spinal palpation and exam., General physical exam., Neurological exam., Orthopedic exam., Neurocalometer exam., Chirometer exam., Neurograph exam., and x-ray studies which included the lateral cervical spine, anterior cervical spine, and dorsal spine.

**Questionnaire Findings:** Show a number of general symptoms. The muscle and joint structure show a weakness of the cervical area of the spine. The gastro-intestinal tract gives evidence of a digestive problem which is responsible for the poor appetite. The Cardio-vascular system gives no evidence of malfunction. The nasal obstruction is related to a sinus condition.

**X-ray Studies and Spinal Analysis:** The spinal examination showed areas of nerve pressure. A major pressure area is located at the atlas-axes area where the nerve carrying the life force to the body passes between the vertebrae. Minor pressure areas are located at the first and second dorsal vertebrae where the nerves to the spine pass between the vertebrae. The spinal X-rays show a definite spinal curvature which is of long standing. The dorsal view shows that the curvature has been developing over a long period of time. The lateral view shows a lordosis condition which is developing rapidly. The AP view shows a definite side slip of the atlas vertebrae. Also the axis and atlas vertebrae are rotated severely. It is my opinion that the atlas vertebrae is subluxated and causing a nerve interference in this area of the spine. With a nerve block of this type you can expect to be under chiropractic care for a definite period of time. A complete correction of the spinal nerve block is the answer to the health problem. With a complete correction a return to better health will follow.

#### **Chiropractic Physical Examination Findings:**

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood pressure: \_\_\_\_\_

Pulse: \_\_\_\_\_ Other findings essentially normal except the above secondary complaints.

**Impressor:** There appears to be a definite relationship between your chief complaint and the findings of the comprehensive examination. The misalignments found in the area of major nerve interference correspond to the other vertebral misalignments. The human spine can accept only so much correction at any one time. Treatment must be directed toward correcting the vertebral misalignments associated with the nerve interference at the area of involvement. It is very possible that compensatory changes resulting from this primary correction of the area of major nerve interference will alter the spinal structure in such a way as to reduce the nerve interference that is causing some of the secondary problems. It should be clearly understood that this case is being accepted on the basis of treatment of the chief complaint only, even though improvement is anticipated in secondary problems.

**Recommendations:** As we wish the very best of health for each patient accepted, we recommend a program

that will provide a solid foundation for the future. The ideal situation is not only to arrest the present development and deterioration of your condition, but further to provide a progressive improvement as the forces of nature in your body become increasingly effective.

In your particular situation, the facts of the examination and our experience with similar cases, suggest that you follow a course of initial correction for a period of approximately 8 weeks. During this time you will need to come to this office for 20 visits. This program will start with:

4 weeks, three visits per week

4 weeks, two visits per week

Chiropractic adjustments will be given to reduce the vertebral misalignments and nerve interference. Spinal exercises will be given to strengthen spinal muscles and give added holding support to the vertebral column.

At the end of this recommended course of initial correction, we will determine the progress you have made by making a detailed comparative chiropractic physical examination (including X-ray studies.) As you follow the principles decided for you, and spend the time necessary, the forces of nature in your body with the help of the nervous system will then produce maximum correction.

**Fee schedule:** The following fee schedule does not include the cost of the original examination and x-ray studies.

For the recommendation initial correction care you may choose any of the following plans.

**Plan 1:** If we must bill you or your insurance company. \$6.00 per call. 20 adjustments @ \$6.00 = \$120.00 Re-exam. and x-rays at the end of 8 weeks \$25.50 Total: \$145.50

**Plan 2:** If paid as received, \$5.00 per call. 20 adjustments @ \$5.00 = \$100.00 Re-exam. and x-rays at the end of 8 weeks \$25.50 Total: \$125.50. SAVINGS: \$20.00

**Plan 3:** If you prefer you can prepay the beginning of each 10 calls and receive a bookkeeping savings of 10%, plus a savings of (½ price) on Re-exam. and x-rays.  
No. 1 payment: 10 calls \$45.00  
No. 2 payment: 10 calls \$45.00  
Re-exam. and x-rays at the end of 8 weeks (½ price) \$12.75  
Total: \$102.75. SAVINGS: \$42.75.

**Plan 4:** If you prefer you may prepay the total amount in the beginning and you will receive a bookkeeping savings of 10% plus no charge for re-exam. and comparative x-rays.  
20 adjustments @ \$5.00 - less 10% discount  
Re-exam. and X-rays at the end of 8 weeks—no charge.  
Total: \$90.00. SAVINGS \$55.50.

The Chiropractic Assistant at the front desk will answer any questions you might have these payment plans. Please speak with her today about which plan will be the most convenient for you.

# *The Role of the Detail Man*

**Dr. Willard Gobbell**  
Family Physician  
Encino, California



**Dr. Jeremiah Stamler**  
Chairman  
Department of Community  
Health and Preventive  
Medicine, and Dingman  
Professor of Cardiology  
Northwestern University  
Medical School



"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

#### **Family Physician's Perception**

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.

"In the total picture of dealing with health problems in this country, there is a potential for detail men to play a meaningful role."

#### **The Positive Influence**

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

## **Is He a Source of Information?**

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

## **Training of Sales Representatives**

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility

of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone

in the health care field, whether they be general practitioners, surgeons or salesmen.

## **Value of Sampling**

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

## **The Other Side of the Coin**

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

## **The Industry Responsibility**

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and

thoroughly trained. That training, perchance, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—i.e., the patients—will be.

## **Physician Responsibility**

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that informa-

tion must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical  
Manufacturers Association  
1155 Fifteenth Street, N.W.  
Washington, D.C. 20005





# Replacing the Doctor Draft

BY MICHAEL HUGHEY, M.D.

*The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.*

In recent years, the armed forces have relied upon the "doctor draft" and the draft-induced participants in the Berry Plan to provide medical officers for the different service departments. With the expiration of the draft, the Department of Defense estimates a physician shortage of 800 by the summer of 1975 and 1800 by 1976.<sup>1</sup> With this shortage in mind, several new programs have been instituted in an attempt to attract more volunteer physicians into the armed forces. It is the hope of the Department of Defense that these programs will be operational by the time the current pool of physicians with previous commitments to the armed forces is exhausted.

In the past years, a limited number of full scholarships have been offered to medical student by the armed forces. Part of Public Law 92-426 provides for expansion of this program.<sup>2</sup> Currently, the Secretary of Defense is authorized to offer 5,000 of these scholarships to students attending medical, dental or any other health profession school located in the United States or Puerto Rico. Students participating in this program are given the rank of 2nd lieutenant or ensign and are paid a stipend of \$400 per month while in school. In addition, all tuition, books, fees, laboratory expenses and other educational expenses are paid, except for room and board.

In return for the scholarship, participants are obligated to serve in the military on active duty the same number of years as they have participated in the scholarship program. Taking a military residency is considered educational and does not count toward the active duty requirement. It does not, however, add additional active duty obligation.

In an effort to keep military physicians in the armed forces, an incentive pay plan is currently under consideration in Congress. As early as 1947, it became clear that special pay rates were necessary to keep older, experienced military physicians in the armed forces. At that time, the first

of a series of special pay bonuses were offered to physicians who intended to make a career in the military. Currently, physicians who have served on active duty for more than two years are eligible for an additional \$150 per month above their normal pay rate. The new bill in Congress would raise this special pay to \$350 per month, an increase of \$2400 a year.

In addition, selected medical officers who have served on active duty for more than four years and who agree to continue on active duty for a variable number of years will be eligible for "incentive pay." This incentive pay will vary according to individual circumstances, but may be as great as \$13,500 per year *in addition* to the normal officer's salary. It is hoped that the combination of these two bonus pay programs will make a career in the Armed Forces financially more competitive with private practice.

Perhaps the most interesting program designed to provide the armed forces with physicians is the Uniformed Services University of the Health Sciences (USUHS). The USUHS, created in 1972 by Congress,<sup>3</sup> will graduate a minimum of 100 medical students annually by 1982. These physicians will have a seven year obligation to the Armed Forces, not counting internship and residency. The purpose of the University is to provide the armed forces with career officers in medicine, dentistry, and the allied health professions.

Clinical training will be provided at the National Naval Medical Center in Bethesda, Walter Reed Army Medical Center, and Malcolm Grow Air Force Hospital. According to Congressman Samuel H. Young (10th District, Ill.), the "national medical school" is expected to be located at Walter Reed Army Medical Center and be "in operation by 1978."<sup>4</sup> However, the development of an interim facility is also being considered which could start a smaller class of medical students within the next two years.

(Continued on page 222)

# Report on Legislation

An attempt to prevent chaos and confusion in physician licensure, and modification of various state health agencies are the thrust of five major bills enacted by the 78th General Assembly.

During its recent session, the General Assembly acted to: prevent home-rule licensure of physicians; exclude physicians offices from "certificate of need" controls; assimilate Illinois residents who attended foreign medical schools into the state's medical care system; improve mental health programs, and establish a Dangerous Drugs Commission which will supervise the state's programs to treat drug abusers.

The proposal establishing a state drug commission has been signed into law; the four other bills await action by Governor Walker.

Nine other major health-oriented bills failed to pass, but are expected to be reintroduced in January. They included proposals to: amend the Blue Shield Law equating chiropractors with doctors of medicine and osteopathy; repeal the state's anti-substitution law; create two new state agencies with broad powers in the health field, and strengthen the state's medical disciplinary system.

Health was an important topic in the legislature this election year. Of the 1,260 measures considered, approximately 179—or one in six—concerned medicine.

The effectiveness of ISMS in influencing the legislative process largely can be attributed to the valuable help provided by the many physicians who participated in the Key-Man Program, and others who worked with various ISMS committees and staff.

Physicians had a voice in the legislative arena by providing expert testimony on various bills, and by phoning, wiring and writing their legislators to express their views on specific proposals.

The following analysis is presented to give you a general view of major health-oriented proposals which were acted upon during the 78th General Assembly. For further information on these or any other proposals, contact the ISMS Governmental Affairs Division.

## MDs Excluded From 'Certificate of Need' Controls

Plans to build, expand, move or sell a hospital, nursing home or surgicenter will require approval of the State Comprehensive Health Planning (CHP) Agency under S.B. 1609 which has been signed into law by Gov. Walker.

A provision in the original bill which would have brought physicians' offices and clinics under "certificate of need" regulation was withdrawn

because of vigorous ISMS opposition.

The new law covers construction or modification plans involving an expenditure of more than \$100,000, or a substantial change in services or bed capacity. In effect, facilities covered by the "certificate of need" umbrella will be shifted into a semi-public utility status.

Under S.B. 1609, local CHP agencies will hold public hearings on all applications for construction or expansion before submitting a recommendation to the state CHP board for final action. The State CHP agency will be required to study: (1) area size; (2) population and growth potential; (3) number of existing and planned facilities offering similar services; (4) utilization of existing facilities and (5) availability of alternative facilities and services before granting approval.

Physicians can play a significant role in the decision-making process through involvement with local CHP agency committees, and by participating in public hearings held to review applications.

## Authority of Mental Health Department Checked

The authority of the Illinois Department of Mental Health to close state mental facilities or significantly alter programs may be sharply checked by a proposal now awaiting action by Governor Walker.

H.B. 2710 calls for amendment of the act codifying IDMH powers and duties, and may force the Department to conduct public hearings and furnish the General Assembly with 240-days notice before undertaking any major action. The measure also directs IDMH to evaluate community needs and consider community opinions regarding any proposed program changes.

H.B. 2710 is a combination of two other proposals introduced during the session, both clearly reflecting discontent with IDMH policies, and concern that these policies often were not in the best interests of the patients and communities involved.

## Dangerous Drugs Commission Formed

Some specific functions of several state agencies—including the Dangerous Drugs Advisory Council—have been consolidated under a Dangerous Drugs Commission (DDC) which will direct the state's programs to treat and rehabilitate drug abusers.

Governor Walker already has signed H.B. 2826 creating the DDC which will monitor educational programs, disburse grants, license facilities to

carry out drug treatment programs and serve as the review body for scheduling controlled substances. The DDC also will plan new programs and evaluate current services in an effort to upgrade treatment.

The proposal received strong backing from ISMS because of the need to coordinate and stabilize rehabilitation techniques and services. Under the DDC, local programs will be freed of many coordination responsibilities and all owed to concentrate on providing treatment.

## Ease Road Into Illinois Medicine For FMGs

Obtaining a license to practice in Illinois may be, temporarily at least, easier for Illinois-born foreign medical graduates (FMGs).

Under two bills passed by the General Assembly and now awaiting action by the Governor, a state-financed clinical training program should encourage these FMGs to practice in Illinois.

S.B. 1621 amends the Medical Practice Act and allows Illinois-born FMGs to enroll in a supervised clinical training program at an Illinois medical school provided they pass an equivalency test. Following completion of the course, the FMG is eligible to take another examination which—if he passes—will certify his training as comparable to that provided in U.S. medical schools. He then may take the state licensure examination.

The bill also allows an Illinois-born FMG who has completed a “fifth pathway” program in another state to take the Illinois licensure examination. The proposal is experimental, however, and automatically will be repealed after four years.

A second proposal, S.B. 1620, earmarks \$60,000 to support the training programs. Exactly how the fund will be distributed among the state's medical schools has not been decided.

## Licensure by Home-Rule Units Blocked

Home-rule units may be denied the power to license physicians, and the state would retain its exclusive licensure authority, if Govenor Walker signs S.B. 1504.

The proposal is a move to prevent local licensure for revenue, and to avoid the tremendous confusion which would result if every home-rule unit established its own licensing standards and procedures.

S.B. 1504 is one of approximately 30 measures dealing with the authority to license various professions which was considered during the past session.

The battle to prevent home-rule units from licensing professionals already licensed by the

state began in 1971 when the new State Constitution was ratified. The Constitution contained strong home-rule provisions which granted new powers to cities of 25,000 population or more and Cook County. Under the old State Constitution, cities and all other units of local government could exercise only those specific powers granted by the legislature.

The battle appeared to end two years ago, however, with the passage of H.B. 3636 which denied home-rule licensing authority. Unfortunately, the Illinois Supreme Court ruled the law unconstitutional and resurrected the prospect of chaos in licensure functions.

## Regulate HMO Development, Services

A nine-member Health Maintenance Advisory Board within the Illinois Department of Public Health (IDPH) will develop standards governing the quality of services provided by Health Maintenance Organizations (HMOs).

Under S.B. 1128—already signed by Governor Walker—IDPH also will evaluate an HMO applicant's ability to meet these standards and refer its findings to the Illinois Department of Insurance which grants HMO certification. In addition, IDPH is required to conduct annual reviews of HMO services.

## Other Action by the General Assembly

Among the health-oriented bills that were not passed—but may be reintroduced in January—are proposals which would:

**Super Agency (S.B. 955):** Consolidate the Departments of Public and Mental Health, Public Aid, Children and Family Services and others into a State Department of Health and Social Services, or “super agency.” ISMS opposed this proposal, contending that IDPH should remain a separate agency. *Referred to House Rules Committee.*

**Repeal Anti-Substitution (H.B. 2136 & 2137):** Abolish the existing anti-substitution law and allow pharmacists to substitute generic equivalents unless the physician specifically prohibits the practice in writing. ISMS vigorously opposed both measures. *Assigned to House Rules Committee.*

**Medical Disciplinary System (H.B. 2886, 2887 & 2888):** Create a disciplinary system to investigate charges of misconduct or incompetence against doctors of medicine and osteopathy, and chiropractors. These three measures were developed by ISMS. *Under study by House Rules Committee.*

**Chiropractic (S.B. 910):** Amend the Blue Shield Law and equate chiropractors with doctors of medicine and osteopathy. Opposed by  
*(Continued on page 224)*

# *Doctor's News*

**"TAP INSTITUTE" SLATED FOR OCTOBER**—The Illinois State Medical Society and the Illinois Hospital Association are co-sponsoring a "Trustee-Administrator-Physician (TAP) Institute," October 4-5, 1974, at O'Hare Regency Hyatt House, Chicago. This institute is designed to help participants develop and implement effective internal programs to assure the quality of care within the hospital. For further information, contact Gaylen Newmark, IHA, 840 N. Lake Shore Drive, Chicago; phone (312) 664-9500.

**CONFERENCE ON DRUG AND ALCOHOL TO BE HELD DOWNSTATE**—The Illinois State Medical Society and the McLean County Medical Society, will sponsor a two-day workshop/conference on drug and alcohol dependencies, October 4-5, 1974, in Bloomington-Normal. The conference will have emphasis on the latest methods of combating drug and alcohol abuse; an outline of the functions of the two new state agencies dealing with drug abuse and alcohol; and an in-depth look at the Illinois Dangerous Drugs Commission and the Illinois State Plan for Prevention Treatment and Control of Alcoholism.

The free clinic approach to drug abuse will be discussed by George R. Gay, M.D., Clinical Director of the Haight Ashbury Free Medical Clinic, San Francisco.

For further information and advanced registration, contact Albert W. Ray, Jr., M.D., ISMS, 360 N. Michigan Ave., Chicago, 60601; (312) 782-1654.

**ISMS STATE FAIR HYPERTENSION SCREENING SUCCESSFUL**—An average of 1054 people per day registered and had their blood pressure taken at the State Medical Society's screening project at the 1974 Illinois State Fair.

Featured for 1973 and 1974 in the Society's Grand Stand exhibit space (for the 26th consecutive year) was a Blood Pressure Center, which had been especially built by Ciba Pharmaceuticals for their nationwide CHEC program. For the 1974 project this sectionalized unit was permanently donated by Ciba to the Illinois State Medical Society. It has been recently learned that one of the reasons for this gift was the excellence of the screening program conducted by the State Society in 1973.

Organized and managed by the ISMS, the 1974 project was staffed for seven days by members of the Respiratory Therapy Department and for two days by members of the Division of Nephrology, both of Memorial Medical Center, Springfield.

**AMA CHIEF PRAISES *Your Personal Learning Plan***—William R. Barclay, M.D., Assistant Executive Vice-President of AMA, recently saw *Your Personal Learning Plan* for the first time, and wrote about it: ". . . an extremely useful booklet which could help any physician irrespective of his type of medical practice to upgrade his skills and to keep abreast of current developments. Ideally, all physicians should have a copy . . . to help them organize their CME."

Do YOU have a copy yet? Over 5,000 have been distributed since publication a year ago—about half at \$1/copy to physicians outside Illinois. That means several thousand Illinois physicians—who may have a copy free—haven't yet requested one.

To get YOUR free copy, just write "Personal Learning Plan" on your prescription form, and mail to: Illinois Council on Continuing Medical Education, 360 N. Michigan Ave., Chicago, IL 60601.

**DR. LAKE MAKING STATE TOUR**—Fredric D. Lake, M.D., President, Illinois State Medical Society, has started his President's Tour. Dr. Lake will attend the following county medical society meetings during 1974-1975:

|              |                        |
|--------------|------------------------|
| September 10 | Sangamon               |
| September 18 | DuPage                 |
| October 8    | Rock Island            |
| November 12  | Lake                   |
| November 14  | Champaign              |
| November 21  | LaSalle                |
| November 26  | Macon                  |
| January 8    | Will-Grundy            |
| January 14   | Winnebago              |
| February 6   | North Side Branch, CMS |

**PYHICIAN IN THE NEWS**—The Chicago Medical School has named five new acting department chairmen; they are: Peter Altner, M.D., Department of Surgery; Lester Cohen, M.D., Department of Medicine; John Keller, M.D., Department of Obstetrics and Gynecology; Agnes Lattimer, M.D., Department of Pediatrics; and Melvin Thorner, M.D., Department of Neurology.

George A. Wiltraikis, M.D., Past President of Kane Medical Society, was recently elected national Surgeon General of the Veterans of Foreign Wars.

**HAND SURGERY COURSE PLANNED**—Robert A. Schenck, M.D., Director, Section of Hand Surgery and Assistant Professor, Departments of Plastic and Orthopedic Surgery, Rush-Presbyterian-St. Luke's Medical Center, will conduct the Second Annual Course in Hand Surgery.

The course will meet each Wednesday evening from 6-7 p.m. at the A. B. Dick Auditorium, RPSL Medical Center, 1753 W. Congress Parkway; Subjects to be presented and dates are:

- Functional Anatomy of the Hand, Sept. 11
- Flexor Tendon Surgery, Sept. 18
- Extensor Tendon Surgery, Sept. 25
- Flaps, Nerve Repair, Dressings, Oct. 2
- Bone, Joint and Rheumatoid, Oct. 9

For information, contact Dr. Schenck, M.D., (312) 848-7773.



Clarence Monroe

#### "Clarence Monroe Day" Honors Retiring Plastic Surgeons

Clarence Monroe, M.D., Oak Park, was recently honored by the Chicago Society of Plastic Surgery with "Clarence Monroe Day" which featured scientific meetings and dinner to commemorate the retirement of the plastic surgeon.

Dr. Monroe, a graduate of Rush Medical College, has been Chief, Plastic Surgeon Section, Division of Surgery, at Children's Memorial Hospital since 1953. Since 1966, Dr. Monroe has done extensive research in the clinical study of bone grafting in the repair of clefts of the alveolar ridge in cleft palate children.

He is Past President of the American Association of Plastic Surgeons, Midwestern Association of Plastic Surgeons and the Chicago Society of Plastic Surgery. Dr. Monroe is a member of the Illinois State Medical Society and is Board Certified by the American Board of General Surgery and American Board of Plastic Surgery.

# Editorials



## ***Immunization Action Month***

The recurrent problem of measles in Illinois during the past few years is a cause of great concern. We should be making every possible effort to diminish the relatively high incidence of this preventable disease. In 1973, a total of 2,162 cases of measles were reported in Illinois, and in that same year Illinois had the dubious distinction of ranking third among the 50 states in the reported number of measles cases.

During the first six months of 1974, a total of 1,744 cases of measles have been reported in Illinois, and at least one death has been attributed to the disease. Individual investigations of 681 downstate cases have been completed by local health departments or Illinois Immunization Program personnel. It was found that 51% of these cases occurred in unvaccinated persons, and 33% occurred in persons who were incorrectly vaccinated. Only 11% had a record of having been correctly immunized. The immunization history of the remaining 5% was unknown. These results, like those reported from other areas, indicate that the cause of the persistence of measles is inadequate use of vaccine.

Joyce Lashof, M.D., Director of the Illinois Department of Public Health, stated, in a letter written to ISMS, "We are determined to raise measles immunization levels significantly in Illinois, and committed to increased efforts toward this end during the coming year."

However, measles is not the only immunization problem in Illinois. Although it is the most severe in terms of number of reported cases, the immunization levels against polio are even lower than the measles immunity levels.

During October, Illinois will participate in Immunization Action Month, a national campaign organized by the Center for Disease Control in Atlanta, Georgia. As a part of this program, Society members who are in appropriate specialties or family practice should utilize the "Immunization Audit Forms." These forms can be attached to patients' records and used as a reminder when immunizations are needed. These forms should be of assistance in alerting the physician to children who have immunization needs and are available from IDPH in Springfield.

Members are reminded of the importance of reporting cases of measles, rubella and polio to the state health department. Any physician who does not have a supply of the necessary report forms, may obtain them from the Illinois Department of Public Health.

With continuing cooperation between the Society and the state health department, we can eventually preclude the need for outbreak control measures by ensuring that each child receives needed immunization at the earliest indicated time.

T. R. Van Dellen, M.D.  
*Editor*

*Note: See special article, October Is Immunization Month, page 208*

# The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

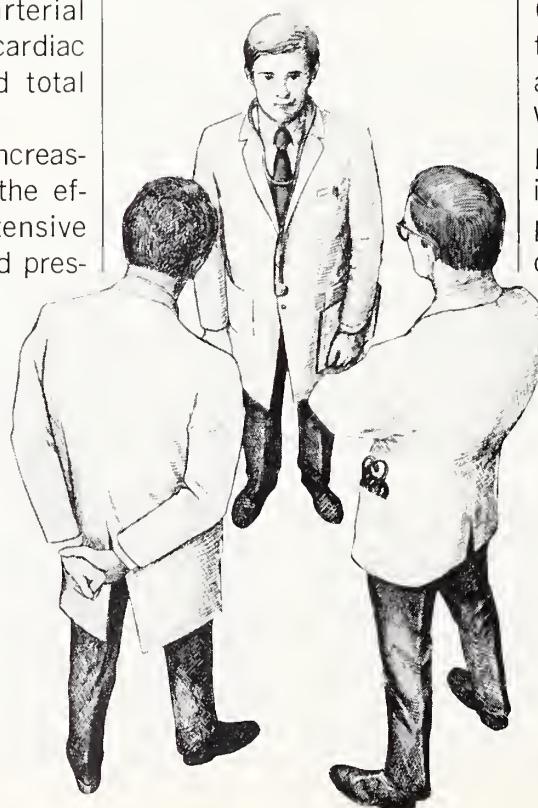
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pres-

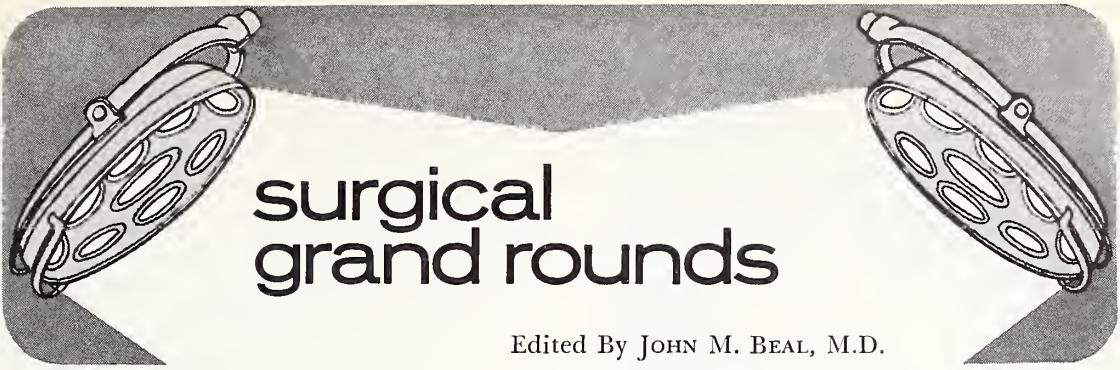
sure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. Does it indeed help lower blood pressure effectively? Is peripheral resistance reduced? Are cardiac output and renal functions main-

tained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in





# surgical grand rounds

Edited By JOHN M. BEAL, M.D.

*Surgical Grand Round are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of Northwestern Memorial Hospital. Patient presentations from Passavant and Wesley Pavilions and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of September 5, 1972.*

## Renal Tumor

**Dr. Edward Kapustka:** A 50-year-old white woman came to the Passavant Emergency Room with a history of lower abdominal discomfort, hematuria with slight dysuria but without frequency of 36 hours duration. A few hours before she entered the Emergency Room she had a tremendous urge to void but had been unable to urinate. In the Emergency Room when she was examined, her bladder was not found to be distended; however, a catheter was inserted and a moderate amount of bloody urine was obtained. She was admitted to the hospital and Gantrisin® was prescribed. Urinalysis at the time of admission showed numerous red blood cells and a few white cells.

Past medical history: She had a right ureteral calculus in 1958. Her family history was significant because both her mother and foster father had died of carcinoma of the kidney. Physical examination revealed palpable, slightly tender right kidney with the lower border at the level of the iliac crest but apparently normal in size and shape. Other organs or masses were not felt. Laboratory findings were: hemoglobin/13.7, hematocrit/43%, BUN/8mqn, creatine/1.1 mqn and creatine clearance/78 cc per minute. An intravenous pyelography was performed prior to cystoscopy.

**Dr. Earl Nudelman:** The intravenous pyelogram shows that there is ptosis and rotation of the right kidney which in many cases is the reason why the right kidney is palpable. There is an area of relative radiolucency in the lower pole of the kidney. There is a space occupied in the lower pole of the right kidney which, at this point, would most likely be a cyst, (Figure 1).

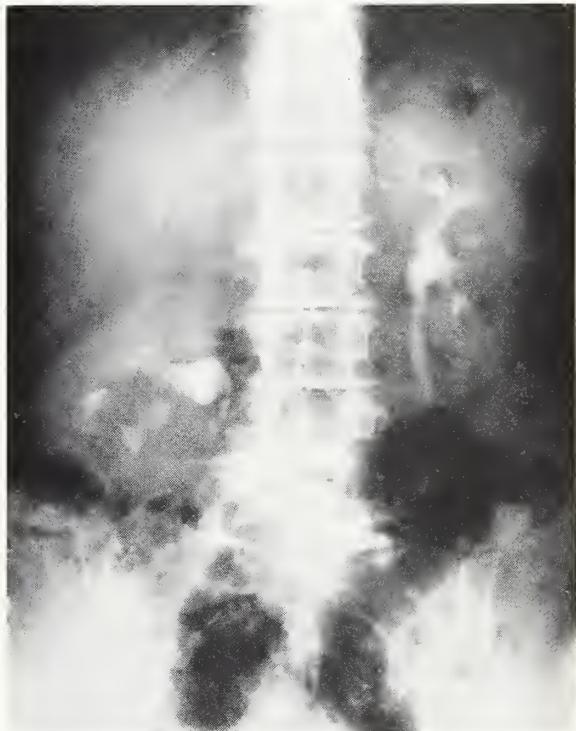


Figure 1. Intravenous pyelogram demonstrated distortion of calyceal system of the right kidney, suggesting a cystic lesion of the lower pole.

**Dr. Kapustka:** Cystoscopy demonstrated no evidence of neoplasm. Because a mass lesion was present in the right kidney, aortography was performed.

**Dr. Nudelman:** This lady has an unusual configuration of the aorta, with sharp angulation. The vessel supplying the upper pole was selectively studied and its branches are normal, (Figure 2). The vessel to the lower pole, the area of



Figure 2. Selective arteriogram shows a normal upper pole of the right kidney.



Figure 3. Aortogram demonstrated a tortuous aorta but there was no evidence of a tumor "blush" in the lower portion of the right kidney.

interest, could not be selectively catheterized. On the studies that we have, there is no evidence of tumor vascularity, (Figure 3). No tumor vascularity is identified in the lower pole area, but without a selective study the examination would have to be considered incomplete.

**Dr. Kapustka:** This presentation demonstrates the difficulty in differentiation between renal tumors and renal cysts radiographically. This patient had a mass lesion in her kidney which most of us thought was a cyst. The problem was presented to the patient. Because neoplasm could not be excluded, the patient accepted exploration for a definitive diagnosis. A right flank incision was made. When the kidney was exposed, a cystic lesion was found in the location that was visualized on the tomogram. However, the lesion did not appear to be a typical serous cyst of the kidney. The wall was thicker and slightly whitish, and there was some slight increased vascularity of the cyst wall. Because the cyst appeared unusual and a tumor might be present, a radical nephrectomy was performed without opening the cyst.

**Dr. Hector Battifora:** The kidney which was sectioned, has a tumor about 5 cm in maximum diameter, (Figure 4). It is a peculiar type of tumor because it has a solid portion and a cystic component. The renal pelvis is not involved by the tumor, and so were the vein, artery and the ureter. Two histological patterns could be discerned. The first was the classical clear cell type or hypernephroma type pattern, (Figure 5). The second was made up of extremely well differentiated cells forming tubule-like structures. In these, apical thickening of the cytoplasm in the manner of brush borders could be seen. Brush borders have been demonstrated by electron



Figure 4. Cross section of removed kidney showed cystic neoplasm in lower pole.



**Figure 5.** Typical clear-cell pattern was found with microscopic examination.

microscopy in well differentiated renal cell carcinoma, thus proving the tubular epithelial histogenesis and laying to rest the adrenal rest theory. Therefore, this is a very well differentiated adenocarcinoma of the kidney which, for some reason, also has a cystic portion. Whether this cystic portion is due to necrosis of pre-existent tumor, or to actual accumulation of secretions, is uncertain.

**Dr. Kapustka:** Renal cell carcinoma is seen twice as frequently in men as women. As the average age of 58 indicates, it is a disease of later life. Currently, the classic triad of gross hematuria, of palpable flank mass, and pain, is observed infrequently in patients with renal carcinoma. In a recent review of 400 patients, 58% had no urinary symptoms; gross or microscopic hematuria was noted in only 32% of the patients. Flank pain was present in 24%, weight loss in 22%, and a palpable mass in 34%. Renal cell carcinoma can be very insidious. Many patients we see present with metastasis. The diagnostic studies will be discussed later. The treatment is basically nephrectomy. As time goes on, a simple nephrectomy has evolved into a more radical procedure which involves taking the perirenal fat, and the paracaval nodes. Unfortunately, in this case we did not secure the vascular pedicle prior to manipulation of the kidney because our preoperative studies suggested the mass present was avascular and probably a cyst. Despite this, the mass was exposed with sharp dissection and a decision was made to remove the kidney on the basis of its gross appearance. The major vessels were isolated and secured individually and the perirenal fat with Gerota's fascia removed. The fat and nodes along the great vessels were removed; the adrenal was not, since the tumor was in the lower half of the kidney.

The survival for patients with renal cell car-

cinoma subjected to nephrectomy approximates 40-45% for five years. Dr. Robson of Toronto, a strong advocate of node dissection, has noted significantly higher 5 year survivals. However, his patients have a very careful preoperative evaluation including chest laminagrams, node biopsy, and even mediastinoscopy in an attempt to identify patients with disseminated disease. Some patients with metastatic carcinoma of the kidney have prolonged survivals. In a group of 93 patients subjected to nephrectomy despite disseminated disease, 14% survived 5 years and some, about 6%, went on to a 10 to 15 year survival. Perhaps these patients somehow altered their immune mechanism and were able to survive much longer. Patients with renal cell carcinoma are recognized to experience spontaneous regression of the tumor. The exact mechanism of this is not understood.

**Dr. John Grayhack:** This patient is of interest from the standpoint of the etiology of her tumor. Her mother and foster father died from carcinoma of the kidneys and now she has an unusual carcinoma of the kidney. No hereditary basis for carcinoma of the kidney has been recognized, but in the July, 1972, *Journal of Urology*, five siblings with bilateral carcinoma of the kidney were reported. This is the most striking observation of a familial incidence of this lesion although parent-sibling and sibling-sibling occurrences have been reported before. So has an association with Lindau's disease. A practical question raised by the mother-daughter incidence of renal neoplasm concerns the extent to which other family members should be surveyed; a reasonable case could be made for pyelographic screening.

The other point of concern is the attempt to make a definite histologic diagnosis by X-ray studies. These studies in this patient disclosed an avascular mass characteristic of a cyst. Although the X-ray studies were not the usual high quality demonstration we have come to expect from Dr. Nudelman because of technical difficulties, even ideal radiographic studies have a recognized fallibility in our experience and that of others. The Cleveland Clinic, recognized for the excellence of its angiographic efforts, recently reported 10 errors in 90 patients with malignancy. X-ray studies may demonstrate a probable avascular mass which is very likely but not certainly non-malignant. It is our practice to recommend exploration of patients with renal masses. That is what we recommended to this patient, although we did tell her that there was at least a 95%

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# October Is Immunization Action Month

BY JOYCE C. LASHOF, M.D., DIRECTOR, ILLINOIS DEPARTMENT OF PUBLIC HEALTH/SPRINGFIELD

During October, Illinois will participate in Immunization Action Month, a national effort to reverse the trend of declining immunization levels, especially among the one-to-four-year age group. These levels have been decreasing at an alarming rate during the past few years.

The recurrent problem of measles in Illinois is of special concern. The continuing relatively high incidence of this preventable disease is shown in the following:

## Measles Incidence By Age Group State of Illinois 1971 - June 30, 1974

| Year | 1   | 1-4 | 5-9   | 10+   | Unknown | Total Cases |
|------|-----|-----|-------|-------|---------|-------------|
| 1971 | 141 | 428 | 1,898 | 745   | 248     | 3,460       |
| 1972 | 365 | 768 | 2,065 | 1,004 | 452     | 4,654       |
| 1973 | 372 | 568 | 766   | 373   | 83      | 2,162       |
| 1974 | 140 | 326 | 638   | 425   | 215     | 1,744       |

At least one death was attributable to measles during the first half of 1974. In 1972, Illinois ranked first among the 50 states in reported number of measles cases. We were third in 1973, and we are in third place through the end of June of this year.

A comparison of change in the downstate measles incidence with that of Chicago may be of interest:

| Period                        | Change Downstate | Change Chicago |
|-------------------------------|------------------|----------------|
| 1972 vs. 1971                 | 11%              | 191%           |
| 1973 vs. 1972                 | 66%              | 22%            |
| 5/31/74 vs. same week of 1973 | 15%              | 48%            |

Of the 932 cases reported downstate as of May 31, 1974, 70% (679) have come from eight counties in the northeast section of the state.

In 1974, 65% of the reported measles incidence, downstate, has occurred in the 5-14-year age group, the mean age being about seven years. This was also the case in 1972 and 1973.

## Percentage Distribution of Measles Cases By Age Category for Downstate and Chicago January 1 - May 31, 1974

| Age Group | Downstate | Chicago |
|-----------|-----------|---------|
| 1         | 2         | 22      |
| 1-4       | 10        | 54      |
| 5-9       | 44        | 16      |
| 10-14     | 21        | 6       |
| 15+       | 6         | 2       |
| Unknown   | 17        |         |
| TOTAL     | 100%      | 100%    |

Personnel of either local health departments or the Illinois Immunization Program have completed individual investigations of 681 (73%) of the 932 downstate cases reported in the first five months of this year. It was found that 51% of these cases occurred in unvaccinated persons, while 33% occurred in persons who were incorrectly vaccinated, e.g., persons who received vaccine under one year of age, or inactivated measles virus vaccine, or live further attenuated vaccine accompanied with gamma globulin. Only 11% had a record of having been correctly immunized, and for 5% the immunization history was unknown. These results like those reported from other areas, indicate that the cause of the persistence of measles is inadequate use of vaccine.

The Illinois Department of Public Health is determined to raise measles immunization levels significantly in Illinois, and is committed to increased efforts toward this end during the coming year.

The state health department has routinely made immunization services available to all of the state's 102 counties. These services include the provision of biologics to local health departments, hospitals and participating private physicians to be administered, at no charge for the immunizing agent, to the public (primarily 12 years of age and younger, at the earliest medically indicated time); the assessment of immunity

levels; surveillance of incidence; educational and motivational activities; and assistance in conducting outbreak control measures.

This year there will be special emphasis in several types of activities. During "Immunization Action Month," the Illinois Department of Public Health will conduct a state-wide program to improve the immunization levels of pre-school-age children. As a part of this program, physicians in appropriate specialties or family practice are being urged to become aware of, and utilize, the "Immunization Audit Forms." These forms are available from Lederle representatives, or from the state health department if your Lederle representative does not have them. The "Audit Forms" can be attached to patients' records and used as a reminder to the physician that immunizations are—or soon will be—needed. In addition, the Illinois Department of Public Health is working with the Office of the Superintendent of Public Instruction in a program to improve compliance with the requirements of the School Code as they pertain to immunization.

One of the most important parts of the state's increased effort will be to provide for any necessary outbreak control measures, including promoting and conducting special emergency clinics when warranted. This activity has been included because, if measles is to be eradicated, or even reduced and maintained at a low incidence, appropriate emergency measures must be taken to contain outbreaks at the earliest time before they develop into epidemics.

And measles is not the only immunization problem in Illinois today. Although it is the most severe in terms of number of reported cases, the immunization levels against polio, for example, are lower than the measles immunity levels.

According to data from the 1973 National Immunization Survey, and from surveys conducted by the Illinois Immunization Program and the Chicago Board of Health, the present percentages of immunity are as follows:

#### CHICAGO (As of June 30, 1973)

|                | Socioeconomic Status | Age         |             |
|----------------|----------------------|-------------|-------------|
|                |                      | 1 - 4       | 5 - 9       |
| <b>Measles</b> | <b>Lower</b>         | <b>75.8</b> | <b>95.1</b> |
|                | Middle               | 78.2        | 96.9        |
|                | Upper                | 90.9        | 97.6        |
| <b>Rubella</b> | <b>Lower</b>         | <b>51.6</b> | <b>66.9</b> |
|                | Middle               | 63.4        | 83.6        |
|                | Upper                | 83.8        | 91.2        |
| <b>DPT/≤3</b>  | <b>Lower</b>         | <b>64.8</b> | <b>89.5</b> |
|                | Middle               | 79.2        | 93.8        |
|                | Upper                | 90.9        | 100.0       |
| <b>Polio</b>   | <b>Lower</b>         | <b>56.0</b> | <b>84.4</b> |
|                | Middle               | 78.2        | 90.6        |
|                | Upper                | 89.9        | 97.6        |

Ideally, people should utilize existing health services, private and public, in their communities, and immunizations should be part of a complete health care program performed under normal conditions. However, in the event of an outbreak, more must be done than merely advising people what services exist. Often routine services are inadequate to handle the problem expeditiously. Even when routine services are available, an outbreak is an indication that too many persons in the community, particularly the parents of young children, have not utilized them, and many children have been left unprotected. This, in turn, means that the immediate problem must be attacked on an emergency basis. Subsequent efforts can then be directed toward motivating routine immunizations through normal services.

The present policy of the Illinois Department of Public Health is to initiate emergency measures within 24 hours of the time that five or more cases of measles are found to exist and to be related epidemiologically. These outbreak control measures should include community-wide notices stating the problem and, usually, special clinics conducted around the outbreak to abort second or third generation cases. Appropriate vaccines, jet injector immunization equipment and available personnel will be provided by the state health department's Immunization Program to assist in these efforts. Local authorities have the primary responsibility to initiate outbreak control measures, and, preferably, this should be done with the knowledge, cooperation and support of the local medical society.

Experience has demonstrated that, when necessary, immunizations can be effectively administered with a high degree of safety in special public clinics. The success of such activities are

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#### DOWNTSTATE ILLINOIS (As of June 30, 1974)

##### Age Group

| Disease Type  | 1-4 | 5-12 |
|---------------|-----|------|
| Measles       | 62  | 80   |
| Rubella       | 61  | 79   |
| Poliomyelitis | 58  | 76   |
| DPT/Td        | 72  | 86   |

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#### **Neurosurgeons on Affiliate Society Council**

The Board approved representation of the Illinois Neurosurgical Society on the ISMS Council on Affiliate Societies upon its organization this fall. INS is the Illinois Section of the Central Neurosurgical Society.

#### **Hospitals and HMO's**

In response to an Illinois Physicians Union request for a position statement on hospitals which establish Health Maintenance Organizations unilaterally without approval of their medical staff, the Board said that—in matters pertaining to the practice of medicine—it opposes any unilateral action by the hospital administration.

#### **TAP Institute**

ISMS will join the Illinois Hospital Association in sponsoring a Trustee-Administrator-Physician Institute October 4-5, 1974, at the Regency Hyatt House in Chicago. The institute is conducted by the Joint Commission on Accreditation of Hospitals.

#### **Illinois Conference on School Health**

ISMS will co-sponsor the 8th Illinois Conference on School Health December 5, 1974, with \$300 being pledged to cover expenses. Richard Dukes, M.D., Urbana, ISMS representative to the Joint Committee on School Health, will deliver the welcome address and Willard Fullerton, M.D., Sparta, will be honored for his many years of service to the committee.

#### **Woman's Auxiliary**

The Board referred to the Committee on Constitution and Bylaws a suggestion that the immediate past president of ISMS serve as the chairman of the Advisory Committee to the Woman's Auxiliary. Present bylaws specify that the ISMS president-elect serve as chairman.

#### **Mileage Allowance**

Effective September 1, all officers, trustees, council and committee members and staff using their personal cars on society business will receive 15 cents mileage allowance. The rate has been 12-1/2 cents per mile.

#### **IDPA Review of Medicaid Physicians**

The Board referred to the Chicago Medical Society an Illinois Department of Public Aid request for assistance in recruiting competent physicians to perform on-site reviews of the quality of care rendered by high volume Medicaid physicians. The Board said that since most of the reviews are done in Cook County, it would be more appropriate for CMS to help IDPA recruit physicians for this work.

#### **ISMS to Move Headquarters**

The ISMS headquarters office, located at 360 N. Michigan, Chicago, since 1960, will be moved about December 1, 1974, to the 35th floor of the Mid-Continental Plaza, a new building located across from Chicago's Palmer House. The Illinois Foundation for Medical Care and the Illinois Council on Continuing Medical Education will share the space.

#### **Immunization Action Month**

At the request of Joyce Lashof, M.D., Director of the Illinois Department of Public Health, the Board endorsed the department's plans for promoting Immunization Action Month in October. Dr. Lashof reported that immunization of pre-school children has been lagging.

## **Revised Budget Approved**

The Board approved a revised budget for 1974 as presented by Mather Pfeifferberger, M.D., Chairman, Finance Committee. The revised budget anticipates increases in both receipts and expenditures.

## **MEDICHEK**

As a followup to House of Delegates' action regarding payment of usual and customary fees under MEDICHEK, the Board directed the Relative Value Study Committee to give priority to gathering data for use in constructing units for MEDICHEK services. This information will be referred to the Illinois Department of Public Aid for modification of its fee structure. In a related matter, the Board authorized expansion of the ISMS Government Health Program Workshops to include instructions regarding completion of MEDICHEK forms. The workshops have previously been providing physicians' medical assistants with information on Medicare, Medicaid and CHAMPUS forms.

## **Quackery**

ISMS will encourage the National Institute of Health to utilize objective, scientific criteria in its study of the fundamentals of the chiropractic profession. It has been reported that NIH's National Institute of Neurological Disease and Stroke has received a special grant for this purpose.

## **Legislation**

ISMS will: (1) seek an amendatory veto of Section 1.5 of S.B. 1676 (Emergency Medical Services Act) to increase protection from liability for doctors, nurses, paramedics and hospitals; (2) seek corrective legislation to modify the inspection provisions delegated to the Dangerous Drugs Commission under H.B. 2826; (3) urge the Governor to sign S.B. 1500, which allows the Department of Mental Health additional time to replace the hospital permit system or prepare permit holders to qualify for license to practice medicine; (4) instruct legal counsel and the Governmental Affairs Council to prepare an in-depth analysis of S.B. 1625, the rate review bill; (5) seek re-introduction of H.B. 2886 and 2887, the medical disciplinary bills, and (6) oppose the amendatory veto of S.B. 1527, a home-rule exemption for sanitarians as requested by the Illinois Public Health Association and Illinois Environmental Health Association.

## **Legislative Committee on Health**

ISMS will recommend to the new special sub committee of the House Human Resources Committee charged with reviewing national health legislation that it address three major federal proposals-national health insurance, health planning and health manpower. ISMS will closely monitor the sub committee's actions and whenever possible submit available information to insure that this committee's recommendations result in meaningful legislation at the state level.

## **Blood Pressure Screening by Blood Banks**

The Board of Trustees adopted a recommendation of the Laboratory Services Committee that ISMS not support the concept of having routine blood pressure screening accomplished by blood banks on a statewide basis since this is not part of the normal procedure and primary responsibility of a blood bank; that any such screening be accomplished in keeping with the established ISMS policy; that it continue to be recognized that blood pressure is important and should be utilized as one of the many parameters within the responsibility of the physician in screening for disease; that the Illinois Heart Association be encouraged to continue in its commendable efforts to detect cardiac disease by providing appropriate facilities and personnel to accomplish screening; and that should local agencies wish to establish blood pressure screening programs through local blood banks, such be accomplished with the concurrence of the county medical society.

## **HCG Weight Clinics**

The Board will ask the Illinois Attorney-General and Department of Registration and Education to investigate HCG weight control clinics for possible violations of the Illinois Medical Practice Act and other laws. ISMS also will request an official opinion from the AMA Judicial Council regarding the ethics of physician involvement with HCG weight clinics. These inquiries will be publicized in ACTION REPORT and special notification will be sent to those counties where such clinics are known to exist.

## **Health Care for Spanish-Speaking Communities**

The Council on Social and Medical Services was authorized to proceed with plans for a Conference on Health Care in Spanish-Speaking Communities. It is contemplated that such a conference would be conducted in cooperation with the Illinois Hospital Association and the appropriate county medical society.

## **Medicare Reimbursement**

The Council on Mental Health and Addiction was requested to supply the Chairman of the Board of Trustees with specific information regarding the council's complaint that psychiatric services are being reimbursed under Medicare at less than other medical services so that appropriate objection can be made with HEW and the Social Security Administration. Copies of the letter will be forwarded to the Governmental Health Program Reimbursement Committee. This committee and the Council on Economics and Peer Review were authorized to inquire if carriers and state agencies are using Current Procedural Terminology III as the universal reporting mechanism for physician services and to ask the AMA Council on Mental Health to encourage its use under federal programs.

## **Mental Health Facilities**

After hearing complaints from several trustees that IDMH zone centers and other public mental health agencies are often closed when their services are needed—and that mental patients are being placed inappropriately in nursing homes because other long-term care facilities are not available—the Board directed the Council on Mental Health and Addiction to study these problems and recommend possible solutions after appropriate discussions with the Department of Mental Health.

## **Publications**

Due to increased printing costs, the Board authorized the Illinois Medical Journal to raise its rates for certain advertising and for reprinting Journal articles.

## **Annual Washington Roundup**

ISMS sponsorship of a vacation trip to Acapulco following the annual Washington Roundup was approved by the Board. ISMS members and their wives will have the opportunity of attending only the roundup, January 19-22, or the combined Washington-Acapulco trip.

## **Alcoholism and Drug Dependence**

The Board endorsed the principal and direction of current activities of the Department of Mental Health's Alcoholism Division regarding establishment of detoxification centers. ISMS will offer assistance in developing appropriate educational curricula as well as continuing review and comment. All county medical societies will be informed of this activity and encouraged to contact the IDMH Regional Alcoholism Coordinator so as to guarantee adequate physician review of local programs. A tentative program outline for the Conference Workshop on Drug and Alcohol Dependencies to be co-sponsored by ISMS October 4-5, 1974, in Bloomington, was presented to the Board.

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
360 No. Michigan Ave. • Chicago, IL 60601 • (312) 782-1654



*Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.*

*If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events.*

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## OCTOBER

### Anesthesiology

#### COURSE III—EKG FOR ANESTHESIOLOGISTS

For: Anesthesiologists. 1-week course, Oct. 28-Nov. 1, 1974, Chicago. **CME Credit:** 35 hrs. (approx.) AMA Category 1. Fee: \$200. Reg. Limit: 35. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

#### ACUPUNCTURE ANESTHESIA

For: All physicians, allied health. Weekly seminar, Oct. 29, 1974, Memorial Hospital of DuPage Co., Elmhurst, Ill. Speaker: H. Hvadala, M.D., Mt. Sinai Hosp. **CME Credit:** 1 hr. AMA Category 1. Sponsor, contact: J. H. Huss, M.D., Dir. Med. Educ., Mem. Hosp. of DuPage Co., Avon Rd. & Schiller St., Elmhurst, IL 60126; (312) 833-1400, ext. 556.

### Basic Science

#### ALCOHOLISM

For: All Physicians, Allied Health. Weekly seminar, Oct. 1, 1974 (NOTE: date changed from Sept. 24), Memorial Hosp. of DuPage Co., Elmhurst, Ill. Speaker: Herbert Neuhaus, M.D., Dept. of Public Health Hosp., Chicago. **CME Credit:** 1 hr. AMA Category 1. Sponsor, contact: J. H. Huss, M.D., Dir. Med. Educ., Memorial Hosp. of DuPage Co., Avon Rd. & Schiller St., Elmhurst, IL 60126.

#### PRESENT DAY USE OF MICROBIOLOGY

For: All Physicians, Allied Health. Weekly seminar, Oct. 22, 1974, Memorial Hosp. of DuPage Co., Elmhurst, Ill. Speaker: Frank Dorrigan, M.S. **CME Credit:** 1 hr. AMA Category 1. Sponsor, contact: J. H. Huss, M.D., Dir. Med. Educ., Memorial Hosp. of DuPage Co., Avon Rd. & Schiller St., Elmhurst, IL 60126.

### Cancer

#### TUMOR BOARD

For: All Physicians. Bi-monthly meetings, Oct. 1 and 15, 1974, 8:30 AM, Westlake Community Hosp., Melrose Park, Ill. **CME Credit:** 1 hr. each, AMA Category 2. Sponsor, contact: Westlake Community Hosp., 1225 Superior St., Melrose Park, IL 60160.

#### TUMORS OF URINARY TRACT

For: All Physicians. Symposium, Oct. 16, 1974, Ruth Lake Country Club, Hinsdale, Ill. **CME Credit:** 3 hrs. AMA Category 1. Reg. Deadline: Oct. 14, 1974. Sponsor, contact: DuPage County Medical Soc., 646 Roosevelt Rd., Glen Ellyn, IL 60137.

### Cardiovascular

#### ECHOCARDIOGRAPHY WORKSHOP

For: Specialists. 4-day workshop, Sept. 30-Oct. 3, 1974, Indianapolis. **CME Credit:** 24½ hrs. AMA Category 1, AAFP. Fee: \$125. Reg. Limit: 50. Sponsor, contact: Postgrad. Med. Educ., Indiana Univ. Sch. of Med., Fesler Hall, 1100 W. Michigan, Indianapolis, 46202. Co-sponsor: Amer. Coll. Cardiology.

#### CARDIAC CLINIC

For: All Physicians. Monthly meeting, Oct. 8, 1974, 8:30 AM, Westlake Community Hosp., Melrose Park, Ill. **CME Credit:** 1 hr. AMA Category 2. Sponsor, contact: Westlake Community Hosp., 1225 Superior St., Melrose Park, IL 60160; (312) 681-3000.

### REHABILITATION FOR RECENT ACUTE MYOCARDIAL INFARCTION

For: All physicians, nurses. Lecture, Oct. 25, 1974, Martha Washington Hosp., Chicago. **CME Credit:** 1 hr. AMA Category 1. Sponsor, contact: F. Lopez-Fernandez, M.D., Med. Dir., Martha Washington Hospital, 4055 N. Western Ave., Chicago, IL 60618.

### BASIC ELECTROCARDIOGRAPHY

For: Family Physicians. 1-week course, Oct. 28-Nov. 1, 1974, Chicago. **CME Credit:** 35 hrs. (approx.) AMA Category 1. Fee: \$200. Reg. Limit: 35. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

### Drug Dependencies

#### CONFERENCE ON DRUG & ALCOHOL DEPENDENCIES

For: All physicians, allied health, school & community workers. Symposium & workshop, Oct. 5, 1974 (plus Oct. 4, for school personnel only), Student Union, Illinois State Univ., Normal, Ill. **CME Credit:** 6 hrs. AMA Category 2. Fee: \$5 (plus lunch). Reg. Deadline: Sept. 27, 1974. Sponsor, contact: Committee on Alcoholism & Drug Dep., Ill. State Med. Soc., 360 N. Michigan Ave., Chicago 60601; (312) 782-1654. Co-sponsor: McLean County Med. Soc.

### Endocrine-Metabolism

#### THYROID DISEASE

For: Family Physicians, Internists, Pediatricians, Nuclear Medicine. 1½-day lecture/round table, Oct. 11-12, 1974, Pfister Hotel, Milwaukee, Wis. **CME Credit:** 10 hrs. AAFP. Fee: \$125. Reg. Limit: 100. Sponsor, contact: Medical Coll. of Wis., c/o A. T. Finnegan, Ofc. of Cont. Educ., 561 N. 15th St., Milwaukee, 53233.

#### SODIUM & WATER METABOLISM

For: All physicians, allied health. Weekly seminar, Oct. 15, 1974, Memorial Hospital of DuPage Co., Elmhurst, Ill. Speaker: A. R. Lavender, M.D., Hines V.A. Hospital. **CME Credit:** 1 hr. AMA Category 1. Sponsor, contact: J. H. Huss, M.D., Dir. Med. Educ., Mem. Hosp. of DuPage Co., Avon Rd. & Schiller St., Elmhurst, IL 60126; (312) 833-1400, ext. 556.

### Family Medicine

#### SHOCK

For: Family Physicians. Lecture/symposium, Oct. 9, 1974, 12:30 PM, Community Hosp., Geneva, Ill. Speakers: R. Lilliehi, M.D., Univ. of Minn. & R. Gunnar, M.D., Loyola Univ. **CME Credit:** 3 hrs. AMA Category 1. Reserv. required for luncheon. Sponsor, contact: Community Hosp., 416 S. Second St., Geneva, IL 60134; (312) 232-0771, ext. 248.

#### MEDICINE FOR TODAY (Fall & Spring Series)

For: Practicing Physicians, House Staff. Lecture series emphasizing Orthopedics, Psychiatry, Endocrinology, Pulmonary Function. Usually weekly, Oct.-Dec., 1974; Feb.-Mar., 1975, at these locations: Belleville, Berwyn, Centralia, Champaign, Chicago (Near West, North, Southwest), Harvey, Hinsdale, Melrose Park, Park Ridge, Peoria, Rockford, Rock Island, Springfield. **CME Credit:** 30 hrs. max., AMA Category 1, AAFP Prescribed. Fee: \$90, AAFP Mbrs., \$100 non-mbrs. Sponsor, contact: Illinois Academy of Family Physicians, 14 E. Jackson Blvd., Suite 1532, Chicago 60604.

### General Interest/CME Methods

#### INTRODUCTION TO CME TECHNIQUE

For: Hospital and other CME program planners. Two identical workshops held simultaneously, Oct. 4-6, 1974, Marriott Inn, St. Louis and Oak Brook Hyatt House, Oak Brook, Ill. **CME Credit:** 14 hrs. AMA Category 1 (plus 4 hrs. extra on completion of post-workshop assignment). Fee: \$125. Reg. Limit: Deadline: 20 each; Sept. 20, 1974. Sponsor, contact: Illinois Council on Cont. Med. Educ., 360 N. Michigan Ave., Chicago, IL 60601.

### General Interest

#### THE OTHER DOCTOR IN YOUR PRIVATE PRACTICE

For: All Physicians & Allied Health. Weekly seminar, Oct. 8, 1974, 11:30 AM, Memorial Hospital of DuPage Co., Elmhurst, Ill. **CME Credit:** 1 hr. AMA Category 1. Sponsor, contact: John H. Huss, M.D., DME, Memorial Hospital of DuPage Co., Avon Rd. & Schiller St., Elmhurst, IL 60126; (312) 833-1400.

### Infectious Disease

#### COURSE IN MODERN CARE OF INFECTIOUS DISEASE

For: All Physicians. Bi-weekly course, 8:00 AM Oct. 5, "Community Acquired Infection;" Oct. 16, "Life Threatening Infections;" Nov. 6, "Danger & Complications of Antibiotics;" Nov. 20, "Infections in the Compromised Host;" Dec. 4, "Diarrheas, Gram Negative, Septicemia, & Shock;" Westlake Community Hosp., Melrose Park, Ill. Speaker: S. Levin, M.D., Rush Medical Center. **CME Credit:** 1 hr. each, AMA Category 2. Sponsor, contact: Westlake Community Hosp., 1225 Superior St., Melrose Park, IL 60160.

### Internal Medicine

#### INDIANA REGIONAL MEETING

For: Internists. Scientific meeting, Oct. 7, 1974, Indianapolis Convention Ctr., Indianapolis. Sponsor: Amer. Coll. of Phys. Contact: D. E. Wood, M.D., 6467 Holiday Drive E., Indianapolis, IN 46260.

### Neurology

#### 3RD ANNUAL CHILD NEUROLOGY SOCIETY MEETING

For: Pediatric Neurologists. Annual meeting, Oct. 10-12, 1974, Hilton Hotel, Madison, Wis. Sponsor, contact: Child Neurology Society, Box 486 Mayo, 412 Southeast Union, Minneapolis, Minn. 55455.

### Nuclear Medicine

#### ADVANCES IN DISEASE DETECTION BY NUCLEAR SCANNING

For: All physicians. Frontiers of Medicine lecture, Oct. 9, 1974, Billings Hosp., Chicago. **CME Credit:** 3 hrs. AMA Category 1, AAFP. Fee: \$20. Sponsor, contact: Frontiers of Med., Univ. of Chicago, Box 451, 950 E. 59th St., Chicago 60637.

### Obstetrics-Gynecology

#### POSTGRAD COURSE IN OB-GYN

For: Ob/Gyn. Lecture, case presentation, discussion, Oct. 24-26, 1974, Ctr. for Cont. Educ., Univ. of Chicago, Chicago. **CME Credit:** 33 hrs. (approx.) AMA Category 1. Fee: \$225. Sponsor, contact: F. P. Zupan, M.D., Chicago Lying-In Hosp., Univ. of Chicago, 5841 S. Maryland Ave., Chicago, IL 60637.

(Continued overleaf)

## Otolaryngology

**OTOLARYNGOLOGY FOR THE FAMILY PRACTITIONER**  
For: All Physicians. Workshop, Oct. 30, 1974, Indianapolis. **CME Credit:** 6 hrs. AMA Category 1, AAFP. **Fee:** \$35. **Sponsor, contact:** Postgrad. Med. Educ., Indiana Univ. Sch. of Med., Fesler Hall, 1100 W. Michigan, Indianapolis, IN 46202.

## Pediatrics

**MANAGEMENT OF PEDIATRIC HEART DISEASE**  
For: All Physicians. 3-day course, Oct. 30-Nov. 1, 1974, Chicago. **CME Credit:** 21 hrs. (approx.) AMA Category 1. **Fee:** \$100. **Reg. Limit:** 45. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

## Pharmacology

**PSYCHOPHARMACOLOGY**  
For: All Physicians. Short course, Oct. 16, 1974, Gary, Ind. **CME Credit:** 6 hrs. AMA Category 1, AAFP. **Fee:** \$35. **Sponsor, contact:** Postgrad. Med. Educ., Indiana Univ. Sch. of Med., Fesler Hall, 1100 W. Michigan, Indianapolis, IN 46202.

## Psychiatry

**PSYCHOANALYTIC STUDY GROUP**  
For: Psychiatrists. Lecture & discussion group series (9 sessions) beginning Oct. 5, 1974, 9-12 AM Northwestern Mem. Hosp., Wesley Pavilion, Chicago. **Hrs. of Instr.:** 3 each. **Fee:** \$125/series. **Reg. Limit, Deadline:** 12; Sept. 27, 1974. **Sponsor, contact:** B. Blackman, M.D., CME Chm., Northwestern Univ., 670 N. Michigan Ave., Chicago, IL 60611; (312) 337-3107.

**PSYCHIATRY FOR THE MEDICAL PRACTITIONER**  
For: All Physicians. 4-day course, Oct. 7-10, 1974, Chicago. **CME Credit:** 24 hrs. (approx.) AMA Category 1. **Fee:** \$175. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

**CURRENT & FUTURE PERSPECTIVES IN DRUG ABUSE**  
For: All Physicians. Lecture, Oct. 16, 1974, 7:30 PM, Forest Hospital Professional Ctr., Des Plaines, Ill. **Speaker:** P. G. Bourne, M.D., Special Action Ofc. for Drug Abuse Prevention, Washington, D.C. **Fee:** \$15 (\$5 students). **Sponsor, contact:** Forest Hospital, 555 Wilson Lane, Des Plaines, IL 60018.

**GENERAL PSYCHIATRY STUDY GROUP**  
For: Psychiatrists. Lecture & discussion group series (9 sessions) beginning Oct. 19, 1974, 9-12 AM, Northwestern Mem. Hosp., Wesley Pavilion, Chicago. **Hrs. of Instr.:** 3 each. **Fee:** \$125/series. **Reg. Limit, Deadline:** 12; Sept. 27, 1974. **Sponsor, contact:** B. Blackman, M.D., CME Chm., Northwestern Univ., 670 N. Michigan Ave., Chicago, IL 60611; (312) 337-3107.

**PSYCHIATRY FOR THE ADOLESCENT**  
For: All Physicians. Lecture, group discussion, Oct. 23, 1974, 10 AM, Bethany Methodist Hosp.; Oct. 23, 6 PM, Lincolnwood Hyatt House; Oct. 24, 10 AM, Belmont Hosp. **Speaker:** Beverley Mead, M.D., Dept. of Psychiatry, Creighton Univ. Sch. of Med. **CME Credit:** 5 hrs. **AMA Category 1. Fee:** \$10 (non-staff, for dinner). **Reg. Deadline:** Oct. 18, 1974. **Sponsor:** FAB<sup>3</sup>-CME. **Contact:** Mr. D. Larson, Bethany Methodist Hosp., 5025 N. Paulina, Chicago, IL 60640.

## Radiology

**DIAGNOSTIC RADIOLOGY**  
For: Family Physicians. 1-week course, Oct. 7-11, 1974, Chicago. **CME Credit:** 35 hrs. (approx.) AMA Category 1. **Fee:** \$200. **Reg. Limit:** 25. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

## Respiratory Disease

**CHRONIC BRONCHITIS & PULMONARY EMPHYSEMA**  
For: All Physicians. Symposium, Oct. 29, 1974, 8:30 AM, Westlake Community Hosp., Melrose Park, Ill. **Speaker:** H. Levine, M.D., Hines VA Hosp. **CME Credit:** 1½ hrs. **AMA Category 2. Sponsor, contact:** Westlake Community Hosp., 1225 Superior St., Melrose Park, IL 60160.

## Surgery

**PRE & POSTOPERATIVE CARE OF PATIENTS**  
For: Surgeons, Surgical Specialists. 4-day course, Oct. 29-Nov. 1, 1974, Chicago. **CME Credit:** 32 hrs. (approx.) AMA Category 1. **Fee:** \$175. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

## Urology

**SPECIALTY REVIEW—UROLOGY**  
For: Specialists. 3½-day course, Oct. 2-5, 1974, Chicago. **CME Credit:** 30 hrs. (approx.) AMA Category 1. **Fee:** \$150. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

## NOVEMBER

## Alcoholism

### FIRST ANNUAL SYMPOSIUM ON ALCOHOLISM

For: All physicians. Nov. 13, 1974, 9:00-11:00 AM, Robt. C. Hartmann, Sr., Auditorium, Martha Washington Hosp., Chicago. **CME Credit:** 2 hrs. AMA Category 1, AAFP Elective. **Reg. Limit:** 110. **Sponsor, contact:** F. Lopez-Fernandez, M.D., Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chicago, 60618.

## Basic Science

### SEX PROBLEMS IN MEDICAL PRACTICE

For: All Physicians, Allied Health. Weekly seminar, Nov. 5, 1974, 11:30 AM, Memorial Hosp. of DuPage Co., Elmhurst, Ill. **Speaker:** D. Renshaw, M.D., Loyola Univ. **CME Credit:** 1 hr. AMA Category 1. **Sponsor, contact:** J. H. Huss, M.D., Dir. Med. Educ., Memorial Hosp. of DuPage Co., Avon Rd. & Schiller St., Elmhurst 60126.

### THE THORACIC OUTLET SYNDROME

For: All Physicians, Allied Health. Weekly seminar, Nov. 26, 1974, 11:30 AM, Memorial Hosp. of DuPage Co., Elmhurst, Ill. **Speaker:** J. Conn, Jr., M.D. **CME Credit:** 1 hr. AMA Category 1. **Sponsor, contact:** J. H. Huss, M.D., Dir. Med. Educ., Memorial Hosp. of DuPage Co., Avon & Schiller St., Elmhurst, 60126.

## Cardiovascular

### MANAGEMENT OF ACUTE MYOCARDIAL INFARCTION

For: All Physicians. Symposium, Nov. 12, 1974, 8:30 AM, Westlake Community Hosp., Melrose Park, Ill. **Speaker:** J. Messer, M.D., Presbyterian-St. Luke's Hosp. **CME Credit:** 1½ hrs. AMA Category 2. **Sponsor, contact:** Westlake Community Hosp., 1225 Superior St., Melrose Park, IL 60160; (312) 681-3000.

## Cancer

### TUMOR BOARD

For: All Physicians. Bi-monthly meeting, Nov. 5 & 19, 1974, 8:30 AM, Westlake Community Hosp., Melrose Park, Ill. **CME Credit:** 1 hr. each, AMA Category 2. **Sponsor, contact:** Westlake Community Hosp., 1225 Superior St., Melrose Park, IL 60160.

## Dermatology

### CUTANEOUS MEDICINE

For: All physicians. Frontiers of Medicine lecture, Nov. 13, 1974, Billings Hospital, Chicago. **CME Credit:** 3 hrs. AMA Category 1, AAFP. **Fee:** \$20. **Sponsor, contact:** Frontiers of Medicine, Univ. of Chicago, Box 451, 950 E. 59th St., Chicago 60637.

## Family Medicine

### FAMILY PRACTICE REVIEW

For: Family Physicians. Nov. 4-8, 1974, Chicago. **CME Credit:** 40 hrs. (approx.) AMA Category 1. **Fee:** \$175. **Reg. Limit:** 50. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

## General Medicine

### WEBER MEDICAL CLINIC Fall SEMINAR

For: Generalists. Seminar, Nov. 2, 1974, Olney Central College, Olney, Ill. **CME Credit:** 4 hrs. AMA Category 2. **Reg. Deadline:** Oct. 25, 1974. **Sponsor, contact:** D. L. Potter, Admin., Weber Medical Clinic, 1200 N. East St., Olney, 62450. **Co-Sponsor:** SIU Sch. of Med.

### CARLE CLINICAL CONFERENCE & LECTURE

For: All Physicians, Dentists. Clinical conference, Nov. 13, 1974, Ramada Convention Ctr., Champaign, Ill. **CME Credit:** 4 hrs. AAFP. **Sponsor, contact:** Carle Foundation, 611 W. Park St., Urbana, IL 61801.

## Infectious Disease

### ADVANCES IN INFECTIOUS DISEASES

For: All Physicians, Nurses. Lecture, Nov. 7, 1974, 11:00 AM, Martha Washington Hosp., Chicago. **Speaker:** M. Mufson, M.D., Univ. of Ill. **CME Credit:** 1 hr. AMA Category 1, AAFP Prescribed. **Sponsor, contact:** F. Lopez-Fernandez, M.D., Med. Dir., Martha Washington Hosp., 4055 N. Western, Chicago, 60618.

## Internal Medicine

### BASIC INTERNAL MEDICINE

For: All physicians. Nov. 11-15, 1974, Chicago. **CME Credit:** 40 hrs. (approx.) AMA Category 1. **Fee:** \$175. **Reg. Limit:** 50. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

## VENEREAL DISEASES

For: All Physicians. Short course, Nov. 13, 1974, Gary, Ind. **CME Credit:** 6 hrs. AMA Category 1, AAFP. **Fee:** \$35. **Sponsor, contact:** Postgrad. Med. Educ., Indiana Univ. Sch. of Med., 1100 W. Michigan, Indianapolis, IN 46202.

### DISEASES OF LIVER & G.I. TRACT

For: All Physicians. Group discussion & lecture, Nov. 15, 1974, 10:00 AM, Belmont Community Hosp.; Nov. 16, 10:00 AM, Lincolnwood Hyatt House; Nov. 17, 10:00 AM, American Hosp. of Chgo., Chicago. **Speaker:** S. E. Goldfinger, M.D., Harvard Med. Sch. **CME Credit:** 5 hrs. AMA Category 1, AAFP. **Fee:** \$10 (non-staff, for dinner). **Reg. Deadline:** Nov. 11, 1974. **Sponsor:** FAB<sup>3</sup>/CME. **Contact:** Mr. J. McCracken, Belmont Community Hosp., 4058 W. Melrose St., Chicago, IL 60641; (312) 736-7000.

### ELECTROLYTE IMBALANCE IN CLINICAL PRACTICE

For: All Physicians, Nurses. Lecture, Nov. 21, 1974, 11:00 AM, Martha Washington Hosp., Chicago. **Speaker:** N. Kurtzman, M.D., Univ. of Illinois. **CME Credit:** 1 hr. AMA Category 1, AAFP Prescribed. **Sponsor, contact:** F. Lopez-Fernandez, M.D., Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chicago, IL 60618; (312) 583-9000, ext. 331.

## Laryngology

### LARYNGOLOGY & BRONCHOESOPHAGOLOGY

For: All physicians. Symposium, Nov. 18-23, 1974, Chicago. **Hrs. of Instr.:** 42. **Fee:** \$300. **Reg. Limit, Deadline:** 20; Nov. 17, 1974. **Sponsor, contact:** Univ. of Ill. Abraham Lincoln Sch. of Med., 1855 W. Taylor St., Chicago, IL 60612.

## Neurology

### NEUROPHYSIOLOGICAL & CLINICAL ASPECTS OF ACUPUNCTURE

For: Physicians, Surgeons, Dentists. 3-day conference, Nov. 7-9, 1974, Hilton Hotel, Madison, Wis. **CME Credit:** AAFP Prescribed, AMA Category 1. **Fee:** \$90 (before Sept. 1); \$110 (after Sept. 1). **Sponsor, contact:** Dept. of Cont. Med. Educ., Univ. of Wis., 610 N. Walnut St., Madison, WI 53706.

## Obstetrics-Gynecology

### FEMALE CLIMACTERIC

For: All physicians, allied health. Weekly seminar, Nov. 19, 1974, Memorial Hospital of DuPage Co., Elmhurst, Ill. **Speaker:** A. Scrommegna, M.D., Michael Rees Hosp. **CME Credit:** 1 hr. AMA Category 1. **Sponsor, contact:** J. H. Huss, M.D., Dir. Med. Educ., Mem. Hosp. of DuPage Co., Avon Rd. & Schiller St., Elmhurst, IL 60126; (312) 833-1400, ext. 556.

### PRACTICAL OBSTETRICS & GYNECOLOGY

For: Specialists & Family Physicians. Short course, Nov. 20, 1974, Airport Holiday Inn, Indianapolis. **CME Credit:** 6 hrs. AMA Category 1, AAFP. **Fee:** \$35. **Sponsor, contact:** Postgrad. Med. Educ., Indiana Univ. Sch. of Med., 1100 W. Michigan, Indianapolis, IN 46202. **Co-Sponsor:** Indiana Acad. Family Phys.

## Orthopaedics

### OFFICE ORTHOPAEDICS

For: All Physicians. Short course, Nov. 6, 1974, Indianapolis. **CME Credit:** 6 hrs. AMA Category 1, AAFP. **Fee:** \$35. **Sponsor, contact:** Postgrad. Med. Educ., Indiana Univ. Sch. of Med., 1100 W. Michigan, Indianapolis, IN 46202.

## Psychiatry

### ON DEATH & THE CONTINUITY OF LIFE

For: All physicians. Lecture, discussion, Nov. 20, 1974, 7:30 PM, Forest Hospital Professional Ctr., Des Plaines, Ill. **Speaker:** R. Lifton, M.D., Yale Univ. **Fee:** \$15 (\$5 students). **Sponsor, contact:** Forest Hosp., 555 Wilson Lane, Des Plaines, IL 60016.

## Respiratory Disease

### RESPIRATORY CARE CONFERENCE

For: All Physicians. Monthly meeting, Nov. 26, 1974, 8:30 AM, Westlake Community Hosp., Melrose Park, Ill. **CME Credit:** 1 hr. AMA Category 2. **Sponsor, contact:** Westlake Community Hosp., 1225 Superior St., Melrose Park, IL 60160; (312) 681-3000.

## Surgery

### SPECIALTY REVIEW, PART I

For: Specialists. Nov. 4-15, 1974, Chicago. **CME Credit:** 94 hrs. (approx.) AMA Category 1. **Fee:** \$350. **Reg. Limit:** 150. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

### BLOOD VESSEL SURGERY

For: Specialists. Nov. 18-22, 1974, Chicago. **CME Credit:** 40 hrs. (approx.) AMA Category 1. **Fee:** \$300. **Reg. Limit:** 40. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

# Edmund Andrews: The Forgotten Pioneer of Chicago Urology

BY JOSEPH H. KIEFER, M.D./CHICAGO

Dr. William T. Belfield has, by universal acclaim, been accorded the honored title of "The Father of Urology in Chicago." A man with a national reputation as a bacteriologist and an eminent surgeon, he began about 1885 to restrict his practice to urology. He was a member of the founding group and the first president of the Chicago Urological Society at its inception in 1903 and he retained his pre-eminent position until his death in 1929.

If Dr. Belfield was the Father of Chicago Urology, there is another man who rightly deserves the title of Grandfather. His name is not mentioned in any of the histories of urology in Chicago and his role in the development of this specialty has not been brought out.<sup>1,2,3,4</sup>

Possibly the reason for this omission is the fact that the first historian, Dr. Kretschmer, in his history of the earliest period, mentioned only the men who were connected with the Rush Medical College. Later historians have apparently taken their cues from him. The period we are talking about is that from 1850 to about 1885.

I found out about Dr. Andrews and his urologic interest only by chance. I have long collected books on the history of urology and some years ago I saw catalogued an item, by one J. Grünfeld, M.D., entitled "Geschichte der Endoskopie," dated 1879.<sup>6</sup> I purchased this small book and, on looking through it, I was surprised to see among those who had helped develop the endoscope, the name of a Dr. E. Andrews of Chicago. I looked up the reference, obtained photocopies from the John Crerar Library, and realized that Dr. Andrews had apparently not only shown a very definite interest in urologic instrumenta-

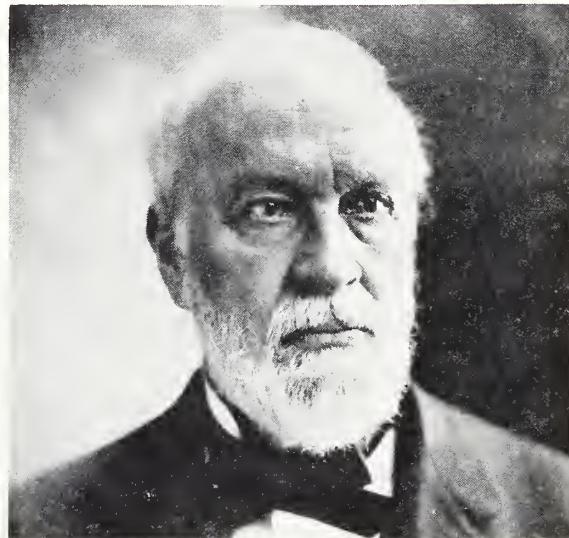


Figure 1. Edmund Andrews (1824-1894).

tion in the pre-cystoscopic days but, also, had reported many cases of instrumental treatment of bladder stone. As far as I can estimate, after reviewing journals of the period, he reported more cases of this type than all of the rest of the surgeons in Chicago put together. That he was acknowledged at the time to be an expert in the urologic field is evident by the fact that, in 1874, he was selected by the Illinois State Medical Society to be chairman of a special committee on urethral strictures. He published over 30 items on urological subjects up to the year 1898, all before the Chicago Urological Society was formed. Despite this, there was no mention of his name in a history of Urology in Chicago until my own "History of Urology in Illinois," published in the *Illinois Medical Journal* February, 1970.<sup>12</sup>

### The Life of the Urologist

Edmund Andrews was born in Putney, Vermont in 1824. His father, the Reverend Elisha Andrews, was a Congregationalist minister. When Edmund was 17 years old, the family moved to Armada, Michigan and in 1846, Edmund went to the University of Michigan which had just opened. He received a Bachelor's Degree in



JOSEPH H. KIEFER, M.D., Chicago, is Professor of Urology, University of Illinois, Abraham Lincoln School of Medicine; Senior Consultant, University of Illinois Hospitals; and attending urologist at St. Joseph's and Augustana Hospitals. He received his medical degree from Northwestern University and is a member of Chicago and American Societies for Medical History.

1849 and began a preceptorship with a Dr. Zina Pitcher. The next year he entered the University of Michigan Medical School which also had just opened, teaching to pay his way. He received a Medical Degree there in 1852 and also a Master's Degree in Arts. Years later, in 1880, he was awarded an honorary LL.D. Degree by his alma mater.

In April 1853, he married Miss Sarah Eliza Taylor of Detroit. They had three sons, Dr. E. Wyllis Andrews, a surgeon, Dr. Frank Taylor Andrews, a gynecologist, and Edmund Lathrop Andrews, an electrical engineer. Dr. E. Wyllis had a son, Edmund, who became a surgeon and died in 1941.

Immediately after graduation, he became a Demonstrator in the Anatomy Department and at once became active in the medical world. He helped organize the Michigan State Medical Society and was Editor of the *Peninsular Journal of Medicine and Collateral Sciences*. In 1855, he was invited to Chicago to become Demonstrator in Anatomy at Rush Medical College. In 1859, he joined the group of insurgents of the Rush faculty who wished to inaugurate a graded curriculum.

At that time, the medical course consisted of a series of lectures extending over about 14 weeks. All students attended these lectures and came back the next year and repeated the same course over. At the end of the second series, they were graduated. The group of Rush professors, under the leadership of Nathan Smith Davis, who wished to set up a graded course of study were voted down by Daniel Brainerd and the majority of the Rush faculty. They, therefore, resigned and organized a new medical school attached to Lind University and Dr. Andrews became Professor of Surgery. Within a couple of years, Lind University dissolved, to be reorganized later as Lake Forest College. The medical school continued independently and was renamed the Chicago Medical School. In 1869, it affiliated with Northwestern University and became its medical school.

About 1856, when Mercy Hospital was organized, Dr. Andrews was named Chief Surgeon and remained so for almost 50 years. From the very beginning, his intention was to practice surgery only and he did no general practice.

In those days, urologic surgery consisted chiefly of operations for bladder stone, either open lithotomy or instrumental by lithopaxy or lithotripsy. There was a small amount of surgery on the external genitalia, such as operations for hydrocele, for varicocele and also orchidectomy

for tumor. Included also was treatment for urethral infections and their sequelae, the chief of which was urethral stricture. Urinary obstruction was treated by catheterization or trocar puncture of the bladder. These procedures were carried out by surgeons who also did every other kind of surgical procedure.

A review of medical journals of that time in Chicago, as well as of the Transactions of the Illinois State Medical Society, reveals that Dr. Andrews published more reports of urologic surgery than any other man. His case books<sup>11</sup> show that he recorded his first lithotomy in 1855 (Figure 2). He soon developed a special interest in urinary tract instrumentation.

Desormeaux of Paris had begun his attempts to design an endoscope about 1853. In 1865, he published a book "De l'Endoscope,"<sup>5</sup> describing the first workable instrument to visualize the urethra and the bladder as well as other organs. The endoscope, while very inefficient by present standards, at least enabled the skilled operator to get a view, poor as it was, of the inside of the bladder. In 1867, a long article by Desormeaux was printed in the *Chicago Medical Journal* in six sections, but no Chicago surgeon, other than Dr. Andrews, seemed to evidence any interest in it.

An article by Dr. Andrews appeared in the *Chicago Medical Examiner* of 1868, describing an improvement on Desormeaux's endoscope by which a magnesium wire was fed into the flame of the oil lamp from which the light was derived (Figure 3). This was an attempt to overcome the poor lighting which was its major defect and which was only overcome when Nitze, more than ten years later, put the light source at the internal end of the tube. Barber, in his History of Urology in Chicago,<sup>3</sup> reported that, in 1882, Rufus Bishop first brought an endoscope to Chicago, but he was obviously unaware of Andrews' much earlier work. This attempt of Andrews was duly reported by Grünfeld in his "History of Endoscopy," where I first saw the name of Andrews mentioned.

In 1871, Andrews made another attempt to improve the light using a row of gas jets 10 inches long as a light source; apparently with no more success.

In 1874, as mentioned above, a special committee of the Illinois State Medical Society was appointed to make a study of urethral strictures and Andrews was named its Chairman. In 1877, he published a study of the mortality of lithotomy in the Lake States as compared to that in Europe, and found it to be definitely higher.

Case 20.

1855. Semisuscepted stone in Bladder.  
Calculus from salivary Gland. His instruments  
made there being now used  
to remove the calculus by the same  
operation. Stone of large as half  
a hen's egg. Patient in favorable  
condition, recovery very rapid.

Figure 2

BY EDMUND ANDREWS, M. D., LL. D., CHICAGO.

One Hundred Operations for Urinary Calculi.

The object of this paper is to compare the safety of litholapaxy with that of lithotripsy and of lithotomy, so far as my own practice is concerned.

The following is a summary of my results:

|  | Cases. | Deaths. | Per cent. of mortality. |
|--|--------|---------|-------------------------|
| Litholapaxy (Bigelow's operation.)             | 40     | 1       | 2½                      |
| Lithotomy (after Sir Henry Thompson's method.) | 6      | 1       | 17                      |
| Lithotomy (at all ages and by all methods.)    | 55     | 7       | 13                      |
| Lithotomy (below age of puberty)               | 26     | 2       | 8                       |
| Lithotomy (above age of puberty)               | 29     | 5       | 17                      |

As all the litholapaxies were done upon adults, the one single death in forty cases contrasts strongly with the five deaths in twenty-nine adult lithotomies.

Figure 5

In 1878, in the *Chicago Medical Journal and Examiner*, he described a sound which he had invented to detect small stone fragments remaining in the bladder after lithopaxy. He called it an "auscultation sound." (Figure 4) It consisted of a metallic sound, hollow, with a rubber tube connecting the end to an earpiece. This would greatly magnify any sound created by contact with tiny stone fragments in the bladder. This was most important in determining completeness of removal of all fragments in the pre-cystoscopic days.

In 1882, he published an article on "Rapid Lithotripsy" in the *Chicago Medical Review*; and, in 1884, another in the *Journal of the AMA* (JAMA) entitled "Rapid Lithotripsy or Litholapaxy." This last term was the name given by Bigelow of Boston to the procedure by which crushing of bladder stone and evacuation of the pieces were carried out at a single setting. In 1889, in *JAMA*, Andrews published a report on the comparative results of lithotomy, litholapaxy, and lithotripsy in 100 operations for stone with a table of results. (Figure 5) These were all his own cases and this report gives an indication of the great interest which he had in urologic surgery.

He kept detailed case and record books in his own hand; these and other memorabilia are in

Figure 4



Figure 2. Record of Dr. Andrew first bladder stone case—1855 or before. Autograph Case Record Books—Northwestern U. Med. Sch. Library.

Figure 3. Apparatus for improving the light for the Endoscope by feeding magnesium wire into the flame of the oil lamp. *Chi. Med. Examiner* 9: 471 1868.

Figure 4. Auscultation Sound. *Chi. Med. J. and Examiner* 36: 597 1878.

Figure 5. Summary of One Hundred Operations for Urinary Calculi, *Trans. Ill. St. Med. Soc.* 39: 173-4 1889.

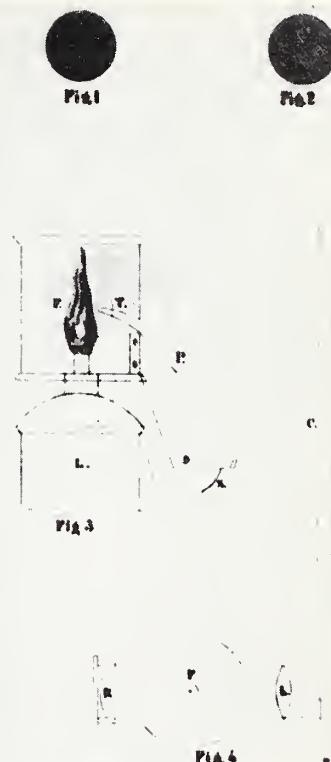


Figure 3

the Northwestern University Medical School Library.<sup>11</sup> (Figure 2)

That Dr. Andrews was generally acknowledged to be the leader in the field of urological surgery is forcefully brought forth in the reports of two meetings of the Chicago Medical Society in 1886. At the February meeting of the Society, Dr. Belfield reported seven cases of digital exploration of the bladder through a suprapubic incision. This was the only method by which exact information about lesions in the bladder could be obtained if sounding for stone did not give a positive answer. It was while doing one of these explorations that Dr. Belfield found a protruding intravesical prostatic lobe and removed it, establishing his priority as the first suprapubic prostatectomist. My main purpose in mentioning this report, however, is to note that the man selected to open the discussion of Dr. Belfield's paper was Dr. Edmund Andrews. Obviously, those of his time thought him best qualified to discuss this urologic procedure. The compliment was returned three months later when, at the May meeting of the Society, Dr. Andrews reported on a new evacuator for litholapaxy and the man chosen to open the discussion on this paper was none other than Dr. Belfield. The line of descent from the Grandfather to the Father of Chicago Urology is here apparent.

This was truly a transition point. Dr. Andrews was, at this time, 62 years old. Dr. Belfield was only 30 and at the very start of his career. Dr. Belfield was already evidencing the special interest in urology which led him to restrict his work to this field and later to found the Chicago Urological Society.

Dr. Edmund Andrews lived to be almost 80 years old, dying on the January 22, 1904, just three months short of that mark. The only account I find of his last illness states that a bladder calculus was diagnosed and removed. A contemporary news account<sup>9</sup> states that Dr. Andrews was operated upon by his two sons, Drs. E. Wyllis and Frank, but I have been unable to learn the nature of the operation. He was said to be doing well and ambulated when, on the sixth day postoperative, he had a sudden episode of respiratory embarrassment. Oxygen was administered, but he died within an hour. The story would be compatible with a coronary attack. Likewise, the death certificate,<sup>10</sup> which gives "acute dilatation of the heart" and "atheromatous vessels with myocarditis," evidently found at autopsy. It is rather tragic that his death was the result of a complication of bladder stone, the disease about which he had thought and written so much and for which he was so expert an operator.

Memorial services were held at the Second Presbyterian Church, where he had been a lifetime member, and were attended by all the medical leaders of the day. Dr. John B. Murphy presided.

Besides urology, Dr. Andrews evidenced special interest in several other fields of surgical practice. One of the most important and one in which he was also a true pioneer was the field of anesthesia. As early as 1868, he reported the use of a mixture of oxygen with nitrous oxide to prevent the asphyxia which was so dangerous with the use of nitrous oxide alone and which, till that time, restricted its use to such operations as dental operations which required only a very short period of anesthesia. There are two major biographical sketches of Dr. Andrews, one by Dr. Arno Luckhardt<sup>7</sup> and the other by Drs. Manuel Lichtenstein and Method,<sup>8</sup> which emphasize his important work in anesthesia, but say little of his urological activities.

He had visited Lister in 1867 and Ludvig Hektoen said he was the first surgeon in Chicago to commend "antiseptic surgery." He urged the use of carbolized water for litholapaxy.

**Figure 6. Urologic Bibliography of E. Andrews**

- 1855 Personal Case Book—Report of his first lateral lithotomy.
- 1867 Trans Ill St. Med. Soc, V5:113. Magnesium wire for endoscopic light.
- 1868 *Chi. Med. Examiner* V 9, p. 468. Magnesium wire for endoscopic light.
- 1871 Trans Ill St. Med. Soc, V 21. Row gas jets 10" long for endoscopic light.
- 1874 Trans Ill St. Med. Soc, V 24. Edmund Andrews, Chairman of Special Committee on Urethral Stricture.
- 1878 *Chi. Med. J. & Examiner* V 36:592. Lithotripsy, Auscultation Sound.
- 1881 *Chi. Med. J. & Examiner* V 43:71. Clinic on Lithotripsy.
- 1882 *Chi. Med. Rev.* V 6:571. Rapid Lithotripsy.
- 1884 *JAMA*, V 2:281. Rapid Lithotripsy or Litholapaxy.  
*JAMA*, V 3:485. Carbolized Water in Litholapaxy—19 cases.  
*Chi. Med. J. & Examiner* V 49:487. Litholapaxy, Varicocele.
- 1885 *Chi. Med. J. & Examiner* V 51:68. Two Cases Lithopaxy.
- 1886 *JAMA*, V 6:626. Rapid Evacuator for Litholapaxy—continuous flow.  
*JAMA*, V 6:626. New Method of Attaching Filiform Guides to Stricture Instruments.  
*Chi. Med. J. & Examiner* V 52:363. Discussion of Paper by W. T. Belfield, "Seven cases of digital exploration of the bladder."  
*Chi. Med. J. & Examiner* V 53:610. New Evacuator for Lithopaxy.
- 1889 *Chi. Med. J. & Examiner* V 58:262. Two Cases in Which Litholapaxy was Impossible.  
*JAMA*, V 12:829. Comparative Results of Lithotomy, Litholapaxy, and Lithotripsy in 100 Operations for Stone.  
Trans Ill St Med. Soc, V 39:173. One Hundred Operations for Urinary Calculus. Also printed in the New Orleans M & S J.
- 1890 Trans Ill St Med Soc, V 40:134. Report on Prostatic Surgery (with Chenoweth).
- 1893 *Chi. Med. Rec.*, V 4:171. Management of Recurrent Urinary Calculi Without Cutting or Crushing.  
*Internal Clinics*, V 1:261. Recurring Calculi from the Kidney and Cure Without Nephrectomy or Litholapaxy.  
*Chi. Clin. Rer.*, V 2:143. The Great Abscesses Situated Behind the Abdominal Cavity.
- 1895 *Chi. Med. Rec.*, V 8:1. Irritable Testis—A Study of a Few Suggestive Cases.  
*Internal Clinics*, V 1:203. Castration for Enlarged Prostate.  
*Chi. Med. Rec.*, V 8:175. Castration in Desperate Cases of Senile Cystitis.
- 1896 *No. Am. Practitioner*, V 8:203. Division of the Vas Deferens for Senile Hypertrophy of the Prostate and Cystitis.
- 1898 *JAMA*, V 30:173. The Oriental Eunuchs.  
*Internal Clinics*, V 3:220. Comparative Results of the Four New Operations for Hypertrophy of the Prostate Gland.

He also wrote many articles on orthopedic conditions, and in his later life, wrote a number of articles on rectal and anal surgery, mostly in collaboration with his son, E. Wyllis Andrews.

He served in the Union Army during the Civil War with the armies of Grant at Vicksburg and with Sherman, and wrote medical histories of these campaigns. He insisted on systematic records, which was an innovation at that time.

He wrote about 14 articles which related to medical history, including the Civil War histories just mentioned. He reviewed the medical history of President Cleveland and the surgical treatment given him at the time of his assassination; and also that of Napoleon III, his illness and death, which followed operations by Sir Henry Thompson for bladder stone.

He showed an unusually inquiring mind and a definite mechanical tendency in his attempts to improve urologic instrumentation, both the endoscope and instruments for transurethral stone crushing and removal. He encouraged the use of litholapaxy, proclaiming its greater safety over open surgery. He must have been a very adept man with transurethral instruments.

Dr. Andrews was elected to the Presidency of both the Chicago Medical Society and the Illinois State Medical Society.

He was said to be a plain, but forceful speaker, without oratorical flourishes. His writings were clear, brief, and in simple language. While not given to levity in his classes or speech, he was said to have a good sense of humor and to be a very friendly person. He was kindly and sympathetic to his patients, of whatever status, rich or poor. It is recounted that the only time he was heard to rebuke a patient was when the patient made a disparaging remark about his former physician. A doctor who knew him well said that he never heard him say an unkind word about any other doctor, certainly not a general trait in those days.

He was said to be able to read Latin, Greek, and Hebrew and even occasionally to compose poetry in Latin or Greek. He was a member of the Chicago Literary Club and had a large library.

Coming as he did, from a religious family, it does not surprise us to find that he was said to be a very religious man but without any ostentation. As one friend said, "He merely lived his religion and never made any show of it." Social activity had no appeal for him.

He was an artist of considerable talent. He illustrated his own articles and painted a series of bird pictures as well as scenes around Memphis and Vicksburg during his military service. He even designed an organ for his church.

Among his non-medical interests, the chief subject was natural science, especially geology and archaeology. He wrote several lengthy articles on the geology of the Great Lakes region.

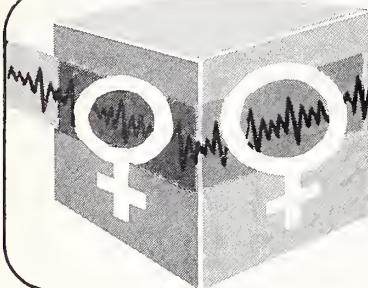
He was a founder, in 1857, of the Chicago Academy of Science and was its president for a number of years. It was said of him that he could have filled a Chair in Geology, in Literature, or in Theology, as well as in Surgery.

Certainly, Dr. Edmund Andrews stands out as the pre-eminent urologic surgeon of the period from 1855 to 1885, until the appearance of men like Drs. Belfield and G. Frank Lydston, and later Drs. Gustav Kolischer and Louis Schmidt, who restricted their entire practice to urology.

It is amazing that a man who did so much in the urologic field and wrote so copiously about it and who was recognized by his contemporaries for his urologic ability was lost to memory. I think that he should be reinstated to his rightful place in the History of Urology in Chicago as an eminent pioneer in urologic surgery, even though he antedated the formation of urology as a separate specialty. ▲

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4. O'Conor, Vincent J.: The History of Urology in Chicago, *J. Int. Coll. Surg.* 39:396, 1963.
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9. *Chicago Tribune*, Jan. 23, 1904.
10. Chicago Board of Health—Death certif. 5946—1904.
11. Autograph Case Record and Account Books, Northwestern U. Med. Schl. Library.
12. Kiefer, Joseph H., History of Urology in Illinois, *Ill. Med. J.* 157:54 Jan. 1970.



## *pulse... of the doctor's wife*

MRS. HAROLD KEEGAN, Editor

## *Back to School*

As the summer draws to a close we leave behind summer vacations, swimming, camps, fairs and "no" auxiliary meetings.

In September everything starts to roll again. The kids are back in school, auxiliary meetings once again begin and also district meetings. This year the district meetings have been divided into smaller groups and more centrally located. All the programs will follow a main theme of Legislation and Communications. Each meeting will have a guest speaker at the luncheon. The morning program will include a sharing of County President's programs, projects and problems, a "Swap Shop" (an idea exchange) and election of district councilors in all the even districts. The District Councilors and County Presidents are working hard to interest many members in attending the meetings.

Legislation has become so important to the doctor it is now time that the doctor's wife assume her role in working for good medical legislation. The district meetings should help inform us about future medical legislation. Also it is a good way to exchange ideas.

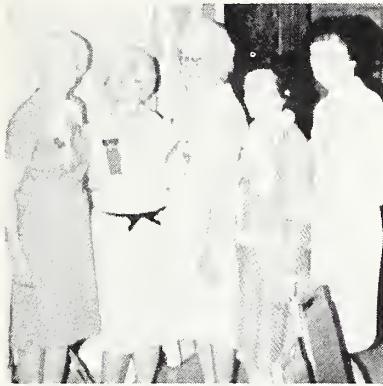
Look for the second quarterly issue of the *Pulse* in September.

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### DISTRICT MEETINGS

|              |               |                             |
|--------------|---------------|-----------------------------|
| September 10 | District 4    | Rock Island Country Club    |
| September 17 | District 5-6  | Pekin Country Club          |
| September 19 | District 1-2  | Elgin Holiday Inn           |
| September 27 | District 11   | White Fence Farms, Joliet   |
| October 10   | District 7-8  | Danville                    |
| November 7   | District 9-10 | Exposition Hall, Belleville |
| February 11  | District 3    | Chicago                     |

## Scenes From National Convention



*Left: Presidents from Illinois gathered during the WA/AMA Convention held last June in Chicago; from left to right: Mrs. Harlan English, WA/AMA Past President; Mrs. Willard C. Scrivner, WA/AMA Immediate Past President; Mrs. Robert Hartman, WA/ISMS Immediate Past President; Mrs. Thomas Glatter, WA/ISMS President; and Mrs. Eugene Vickery, WA/ISMS President-Elect.*



*Right: During the installation reception Mrs. Eugene Vickery chatted with the newly installed WA/AMA President from Hawaii, Mrs. Howard Liljestrand. Below: Mrs. Willard C. Scrivner is welcomed back home with a gift from the Illinois auxiliary. Presenting the gift is Mrs. Thomas Glatter.*



## Salute To Our Two Secretaries



Mrs. Leo V. Kempton, a member of the DuPage County Auxiliary for 12 years, is serving this year on the State Board as Recording Secretary. Alice has been a very busy gal. On the County level she has served as President, Vice-president, Director, Recording Secretary, AMA-ERF Chairman, Health Careers Chairman and Yearbook Chairman. On the State level Alice has served as Hospitality Chairman, Aging and Homebound Chairman and filling a vacancy last year as Recording Secretary.

Alice, originally from Wisconsin, and her husband, a psychiatrist in private practice in Elmhurst, live in Itasca, where she is active with the local FISH group and the Rush Faculty wives.



Mrs. L. P. Johnson, our Corresponding Secretary, is a charter member of Winnebago County Auxiliary and has served on the County Board in various capacities for 14 years. This is her first year on the State Board.

Cathy and her husband, a general practitioner and Assistant Dean of the Rockford Medical School, have three children. Even though she is a new grandmother, she still has time to do volunteer work for Swedish-American Hospital and the Rockford Museum.

## Replacing the Doctor Draft

(Continued from page 196)

By means of these three programs, the civilian student scholarship plan, the incentive pay for career officers, and the establishment of a national medical school, the Department of Defense is hopeful that its needs for physicians can be met without the use of the Selective Service System. It is impossible to predict whether this plan will be successful, but there are no plans in the immediate future for re-instituting the "doctor draft."

### References

1. Fact Sheet, Subject: Special Pay for Medical Officers of the Uniformed Services (Medical Officers Variable Incentive Pay), D. of D., undated.
2. Public Law 92-426, 92nd Congress H.R. 2, September 21, 1972, Chapter 105, Sections 2120-2127.
3. Public Law 92-426, 92nd Congress H.R. 2, September 21, 1972, Chapter 104, Sections 2112-2117.
4. Private Communication, May 17, 1974.

## EKG of the Month

Continued from (page 191)

Answers: 1. A,B,C 2. A,B,D,E

The ECG shows large Q waves in leads V<sub>1</sub> to V<sub>4</sub> in the precordial leads with a QRS duration of 0.14 seconds and left axis deviation. Patients who

develop QRS prolongation with an acute myocardial infarction may have a mortality of 46% or higher. This may not be due to complete heart block. The usual cause of death in these patients is left ventricular failure manifested as congestive heart failure, cardiogenic shock, or pulmonary edema. This patient sustained an acute anteroseptal myocardial infarction with complete right bundle branch block and left anterior hemiblock. This ECG speaks for severe coronary artery disease and also helps explain why so many of these patients die in the acute phase of the myocardial infarction with left ventricular failure. A careful review of the patient's old hospital record would be important since his problem now is non-cardiac. Those patients who survive this attack may be in danger of complete heart block or sudden death. The data in the literature is incomplete on this point. His bundle recording may be helpful in these patients. In one series 8 of 11 patients with a prolonged H-V interval died while only one of three patients with a normal H-V died. The H-V would reflect trifascicular disease in these cases. (Lichstein et al Amer. J. Cardiol. 32:913-918, 1973). Most authors would recommend pacemaker implantation permanently while recognizing the yield would be small because of the accompanying severe left ventricular disease. ▲

The advertisement features a central logo for "75 YEARS" above the words "Professional Protection". Below this, the text "CONTINUOUSLY" and "Since 1899" is displayed. Underneath, the company name "THE MEDICAL PROTECTIVE COMPANY" is written in a bold, serif font, with "FOR WAYNE, INDIANA" in a smaller font below it. At the bottom, contact information is provided for the Chicago Area Office and Springfield Office.

CHICAGO AREA OFFICE:  
T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives  
815 Commerce Drive, Suite 102, Oak Brook, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative  
426½ South Fifth Street, Springfield 62701 (217) 544-2251

## Rehabilitation Of the Patient With Chronic Low Back Pain (Continued from page 190)

tion insurance carriers need to learn this, too.

Our own experience has shown us that a comprehensive program of evaluation and treatment, as spelled out in this paper, does help the vast majority of our patients with chronic low back pain. However, it must be emphasized that the physician must exercise a great deal of patience and persistence if he is to achieve successful outcomes. Obviously, for the patient, the reward is worth the effort invested. ▶

### References

1. Kottke, F. J.: "Evaluation and Treatment of Low Back Pain Due to Mechanical Causes." *Arch. P.M.&R.* 42:6-426 June, 1961.
2. Fordyce, W. E.: Psychology, "Social Work and Medicine." *Arch. P.M.&R.* 52:9-402 September, 1971.
3. Inman, V. T., and Saunders, J. B. de C. M.: "Referred Pain from Skeletal Structures." *J. Nerve and Mental Diseases* 99:660 May, 1944.

## October Is Immunization Action Month

(Continued from page 209)

enhanced if the clinics are supported by the local medical society, in that private physicians are more likely to recommend acceptance by

parents, respond better to possible complaints of reactions to the vaccine, and actively participate by staffing clinics or signing a standing order and serving as emergency medical resources for clinics where needed.

In an effort to make parents of young children more aware of the importance of complete immunizations, intensive educational, informational and motivational programs will be conducted throughout the state during "Immunization Action Month." The primary purpose of the campaign will be to increase immunity among the inadequately immunized, or unimmunized preschool-age population.

The Illinois Immunization Program is planning to distribute posters, brochures, immunization record cards, bookmarks, television and radio public service announcements, and has made arrangements with several dairies to print the recommended immunization schedule on the sides of milk cartons.

It is expected that as a result of this massive public awareness campaign, private practitioners and local health departments will experience an increased number of requests for measles, rubella, polio and DPT/Td immunizations. "These activities," are designed eventually to preclude the need for outbreak control measures by ensuring that each child receives needed immunizations at the earliest time they are indicated. ▶

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Out of Town Call Collect: 217 384-4103

## **Legislative Report** (*Continued from page 198*)

ISMS. Tabled in House.

**Rate Review (S.B. 1625)**: Create an Illinois Health Finance Commission to regulate rates charged by state hospitals, extended care facilities and surgicenters. *Referred to Senate Public Health Committee.*

**Protection for Newborn (S.B. 1214)**: Amend the Illinois Insurance Code to recognize the newborn as a person, and outlaw insurance policies containing disclaimers of coverage for the newborn. This ISMS proposal was *assigned to the Senate Rules Committee.*

**Medical Research (S.B. 1670)**: Require state regulation of all medical research through a Research Review Committee, and mandate that possible side effects of research be explained

to all human subjects. *Tabled In House.*

**Student Loans (H.B. 2757 & 2805)**: Provide \$400,000 for loans to medical students who agree to practice at least four years in physician-short areas of Illinois designated by the Department of Public Health. The loans program is *on the House Interim Study Calendar*, and the appropriation is *under study by the House Committee on Human Resources.*

**Drivers License Advisory Board (S.B. 1643)**: Create within the Department of Public Health a Drivers License Medical Advisory Board to establish standards relating to physical conditions affecting a driver's ability to safely operate a vehicle. *Under study by Senate Public Health Committee.* ▲



## **Conference Workshop On DRUG and ALCOHOL DEPENDENCIES**

**October 4, 1974**

**Ramada Inn,  
Bloomington, Ill.**

**Principal Discussant:**

**George R. Gay, M.D., Director of Clinical Activities,  
Haight-Ashbury Free Medical Clinic, San Francisco**

Physicians, school nurses, school counselors, school administrators, allied health personnel, emergency department personnel, pharmacists, enforcement (youth) officers, community workers and interested persons are invited to attend one or both days of the workshop.

**October 5, 1974**

**Union, Illinois State University,  
Normal, Ill.**

Subjects to be discussed include:  
The Abusive Substances Problem in the Schools  
The View of Enforcement Officials  
Teaching About Dependencies  
What To Do Until The "Doctor Arrives  
Drugs and the Law  
What is Dependency?

---

Advance registration will be accepted until September 27, 1974. For information, write or phone, Illinois State Medical Society, Division of Scientific Services, 360 N. Michigan Ave., Chicago 60601; 312-782-1654.



# report

Illinois Society  
American Association of Medical Assistants

## Chicago Chapter - AAMA Presents 1974 Annual Symposium

### ***"From the Woman's Point of View"***

**Wednesday, October 16, 1974, McCormick Inn  
23rd and the Lake Chicago**

|           |   |            |   |
|-----------|---|------------|---|
| 8:15 A.M. | Registration, rolls and coffee  | 10:15 A.M. | Dr. Maceo R. Ellison, Associate Professor of Medicine, The Chicago Medical School<br>"Hypertension" |
| 8:50 A.M. | Welcome, Mrs. Florence Peery,<br>President, Chicago Chapter   | 11:00 A.M. | Judy Schuppien<br>Rape Crisis Line  |
| 9:00 A.M. | Mr. Ronald E. Przybylski<br>Clinical Information Systems<br>Salesman, Ames Company  | 11:45 A.M. | Dr. Jack C. Berger, Psychiatrist<br>"Emotional Aspects of Menopause, Hysterectomy and Rape."        |
| 9:15 A.M. | Dr. Helen Wilks<br>Diabetes Foundation of Greater<br>Chicago  | 1:00 P.M.  | Luncheon, Dr. Thomas R. Harwood Master Of Ceremonies  |
| 9:45 A.M. | Dr. Robert C. Stepto, Chairman,<br>Department of Obstetrics and<br>Gynecology, The Chicago Medical<br>School "Menopause and the<br>Myths and Facts about Hysterectomies." | 2:00 P.M.  | Mrs. Dorothy Ritchey, Chicago<br>YMCA<br>Yoga Demonstration   |
|           |   | 2:30 P.M.  | Door Prizes<br>Registration \$8.50<br>Non-Members \$9.00<br>(includes luncheon)                     |

*"From the Woman's Point of View" — 1974 Annual Symposium, Chicago Chapter, Wednesday, October 16, 1974 — McCormick Inn, Chicago*

Registration — \$8.50 non-Members — \$9.00

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Make checks payable to CHICAGO CHAPTER — AAMA, 1974 Symposium. Send to Mrs. Bonnie Harper, 12434 South Yale Avenue, Chicago, 60628. Reservations Deadline: October 11, 1974.

# Primary Ovarian Pregnancy

(Continued from page 188)

blood clots. Several placental villi were noted. Section revealed uterine tube with its characteristic mucosal surrounded by connective tissue and slightly dilated blood vessels.

**Diagnosis:** Ectopic pregnancy of ovary. Uterine tube, no pathological diagnosis.

The course of the patient's illness after the operation was uncomplicated and left the hospital after a week in an excellent condition. ▶

## References

A complete bibliography for "Primary Ovarian Pregnancy" may be obtained by writing the *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago, 60601.

# Renal Tumor

(Continued from page 207)

chance that this was a benign lesion. The exploratory procedure was modified on the basis of the X-ray study so that we looked at the lesion first. If the lesion had demonstrable neovascularity we would secure the pedicle and often remove the kidney and lesion on the basis of the clinical history and X-ray studies with further evaluation.

**Dr. John Beal:** So you think that all cysts should be explored?

**Dr. Grayhack:** No, not all of the avascular masses. I think it depends upon the patient's general condition, but if the patient's general condition is satisfactory, exploration is preferable in our opinion.

**Dr. Battifora:** What was the nature of the fluid?

**Dr. Grayhack:** It was clear. The cystic portion of the lesion looked like a simple serous cyst. Although tumors with significant necrosis are not uncommon, association of carcinoma of the kidney and typical serous cyst are rare.

**Dr. Harold Method:** With the operative diagnosis of simple cyst, what did you think caused the hematuria?

**Dr. Grayhack:** She had a positive urine culture on cystoscopy and she had a classic cystoscopic appearance of hemorrhagic cystitis. The cystoscopy did not disclose a neoplasm, but the patient did have submucosal hemorrhages. With this finding, the patient's symptoms, and the positive urine culture, it seems likely that the bleeding was from the lower urinary tract. ▶

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**West:** Oak & Dale Professional Bldg., Suite 111,  
211 W. Chicago Ave., Hinsdale • Call: 654-8448

**Southwest:** 5718 W. 95th St.,  
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**In Rockford:** 1111 S. Alpine Rd., Suite 302,  
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## COOK COUNTY

### Graduate School of Medicine

#### CONTINUING EDUCATION COURSES

STARTING DATES, 1974

SPECIALTY REVIEW COURSES IN HEMATOLOGY, INFECTIOUS DISEASES & NEPHROLOGY, Sept. 30

SPECIALTY REVIEW IN SURGERY, PART 1, Sept. 30 & Nov. 4

SPECIALTY REVIEW IN MEDICINE, RECERTIFICATION, October 14

SPECIALTY REVIEW IN OBSTetrics & GYNECOLOGY, Oct. 28

SPECIAL COURSE IN GYNECOLOGIC PATHOLOGY, Oct. 14

STATE & NATIONAL BOARD REVIEW, Basic & Clinical, Oct. 14 & 20

MANAGEMENT OF COMMON FRACTURES, One Week, Oct. 28

BASIC ELECTROCARIOGRAPHY, One Week, Oct. 28

BASIC INTERNAL MEDICINE, One Week, November 11

FAMILY PRACTICE REVIEW, One Week, November 4

DIAGNOSTIC RADIOLOGY, One Week, October 7

PSYCHIATRY FOR THE MEDICAL PRACTITIONER, 4 Days, Oct. 7

SEXUALITY FOR THE PHYSICIAN, One Week, Oct. 21

PRE & POSTOPERATIVE CARE OF PATIENTS, 4 Days, Oct. 29

BLOOD VESSEL SURGERY, One Week, November 18

ADVANCES IN OBSTetrics & GYNECOLOGY, One Week, Nov. 18

Information concerning numerous other continuation courses available upon request.

Address:

REGISTRAR, 707 South Wood Street,  
Chicago, Illinois 60612

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.*

**ALEDO:** Mercer County, 17,000 population, needs additional family physicians. 4 active physicians at present. General acute hospital in Aledo. High quality medical care economically rewarding. Thirty miles from metropolitan quad-city area. Good small community for family living. Contact: Shirley Lindberg or Monty McClellan, M.D., 308 NW Fourth Street, Aledo, 61231, 309/582-5156. (10)

**BLOOMINGTON:** General Practitioners, Internists, Pediatricians and a Surgeon needed to help establish a multi-specialty clinic in a new Erdman Building. Corporate practice with all the usual benefits. Contact: Paul G. Theobald, M.D., #1 Medical Hills Dr., Bloomington, 61701, 309/828-6051. (10)

**CHARLESTON:** Small midwestern University Health Service serving 8,000 students, 4½ day week; no after hours or weekends. Perfect for post-retirement. Five weeks vacation and one week for medical meetings. Life insurance, health insurance, and University Retirement System. Contact: Director, Health Service, Eastern Illinois University, Charleston, 61920, (217) 581-3013. (10)

**CHENOA:** Rural area, 100 miles south of Chicago on I-55. Looking for one or two physicians to do family practice. Hospital facilities nearby. Financial assistance and office space can be arranged. Contact: R. J. Walker, National Bank of Chenoa, Chenoa, 61726, 815-945-2311. (10)

**CHICAGO:** Board Certified or eligible, Internal Medicine, Illinois Registration, Medical Center, providing preventive and therapeutic medical care with other specialists and diagnostic services on premises. Administrative Ability an Asset, Salary Open, Commensurate with background and experience. Call Collect: William A. Hutchison, M.D., Union Medical Center, 1657 West Adams, Chicago, 60612, (312) 829-1134. (10)

**CHICAGO:** General Practitioner - full time; centrally located, with no weekends or nights; work on standards for rating disability; evaluation of medical impairment. U.S. Railroad Retirement Board, Attention: J. E. Schwartz, Chief D&H, 844 Rush Street, Chicago 60611. (1)

**CREVE COEUR:** M.D. URGENTLY NEEDED as an associate in a very active practice in the Peoria area. hospitals. Present M.D. wishes to retire soon and is Family or General Practice within six miles of three hospitals. Present M.D. wishes to retire soon and is concerned with his patients. Financial arrangements and over-all needs negotiable. Only those seriously interested in private practice call collect 309-699-8022

or 309-699-5525 or write William Long, M.D., Creve Coeur, Ill, 60601. (2)

**DEKALB:** Northern Illinois University Health Service needs Internist; General Practitioner; and Gynecologist or practitioner with wide experience in gynecology and family planning. Reduced paper work, better hours, inquiring patients, new health care delivery systems, and University atmosphere provide interest. Illinois license required. Equal Opportunity Employer. Write L. W. Akers, M.D., Director. NIU Health Service, DeKalb 60115. (10)

**FLORA:** Population 6,000, Patient-drawing area larger. G. P., Internist, Pediatrician. Group or solo. Office space can be arranged to suit your needs. Unusually well-equipped small hospital with excellent lab and X-ray facilities and ICU. Nearby specialty consultants. Fine school system and availability of homes. For information contact: Administrator, Clay County Hospital, Flora, 62839, 618-662-2131. (10)

**GENESEO:** Family Practice; Ped., Ob-Gyn, Int. Medicine who will also do General Practice. Population 7,000 serving area 30,000 on Interstate 80, 2½ hrs. from Chicago, 25 miles from Quad-Cities metropolitan areas, over 300,000. Safe, ideal, small city living, 110 bed ultra-modern hospital, excellent schools, recreational facilities. Hospital has just completed construction of two new modern doctor's offices on hospital property which are available immediately. Guarantee monthly gross income. Clement G. McNamara, 210 W. Elk St., Geneseo, 61254. Call collect (309) 944-6431. (10)

**GENEVA:** GP's or Internists - Outstanding area with unlimited practice opportunities needs you to grow with us. Ideal location for family living in the heartland of the Midwest. Geneva offers the charm of "new England" background - and all only 35 miles from the cultural and medical education advantages of Chicago. Contact: Peter G. Gilbert, M.D. c/o Community Hospital, Geneva 60134 (312-232-0711). (1)

**HARVARD:** Population 5,200, estimated trading area 20,000. Three physicians at present, previously five. Center of rapidly growing and financially sound area. 65 miles northwest of Chicago, 30 miles east of Rockford. Contact: J. M. Holcomb, Harvard Com. Hosp., Grant & McKinley Sts., Harvard, 60033. (10)

**KEOKUK.** Expanding Clinic with new offices in progressive general hospital offers exceptional opportunity to G.P.'s Internists/Cardiologists, General Surgeon willing to do some G.P. Guaranteed salary, no investment. Group membership one year or less. Surgeon, G.P., OB/Gyn, Pediatrician. Ideal environment. Community 16,000; service area 50,000. Contact Fred

Shrimpton, Administrator, St. Joseph Hospital, Keokuk, Iowa 52632, 319-524-2710. (12)

**LIBERTYVILLE**—Thirty-Five miles northwest of Chicago. Population 12,000—serving 40,000. Group practice of Family Physicians. Affiliated with a 175 bed hospital. Corporation benefits. Salary guarantee. Beautiful country for lake sports. Contact: Dr. Mark Fields, 716 S. Milwaukee Rd., Libertyville 60048, 312-362-1390. (10)

**METROPOLIS**: Physicians wanted. Complete office facilities. Financial assistance available. Modern, well equipped hospital serving tri-county area in scenic southern Illinois. Contact: Charles Russell, Administrator, Massac Memorial Hospital, Metropolis, 62960, (618) 524-2176. (10)

**MONMOUTH**: Services area population 30,000. Opening for Family Practice and OB-GYN. Modern well-equipped hospital—141 beds. Near Highways I-74 & I-80. Daily rail to Chicago. Flight service available. Safe place to raise family. Near medical school, liberal arts college. Contact: Roger E. Gurholt, 1000 W. Harlem Ave., Monmouth, 61462. 309-734-3141. (10)

**MORRIS**: Associate wanted - internist, GP, surgeon; growing general practice near Chicago - population 9,000, lovely clean city. Large new office newly equipped. Hospital close. Attractive financially. Keep all you earn Share office overhead only. Contact: Dr. V. L. Hicks, Bedford Plaza Center, Morris 60450 (815-942-4067). (1)

**NASHVILLE**: Board certified or eligible surgeon - must be willing to do general practice - 3,000-14,000 - 72 bed JCAH hospital - 50 miles east of St. Louis - excellent schools and churchs - outstanding area to live - assistance available - Contact: T. K. Janssen, 603 South Grand Ave., Nashville 62263 (618-327-8236) (1)

**PITTSFIELD**: Need family practitioners and surgeons interested in locating in rural community area. Population 4100; area 18,000. Excellent opportunity for someone wanting to practice in a rural community. Located between Jacksonville and Quincy, on Highway 54 and 36. Contact Dr. T. C. Bunting, Illini Community Hospital, Pittsfield 62363. AC 217-285-2141 or 217-285-2113. (12)

**ROLLING MEADOWS**: Population 20,000. Five physicians at present. 25 miles from Chicago. Loan available to start practice. One mile from 450 bed Northwest Community Hospital. Good office facilities for one or more Family Practitioners, Internists, Pediatricians. Nearby College. Contact: Keith G. Wurtz, M.D., 1430 N. Arlington Hts., Arlington Hts., 60004 (312-255-3313) (1)

**SAVANNA**: Pediatrician, Internist, or General Practitioner. Illinois community of 5,000 population on Mississippi River. 40-bed open staff hospital; exceptional recreational facilities; excellent schools and churches of all denominations. Option to practice alone or in partnership. Contact: William J. Dayton, 202 Meadowview Knoll, Savanna, 61074, 815-273-2755. (10)

**SHELBYVILLE**: Population 6,000—drawing population 22,000. New eight man medical ctr. recently opened and attached to 100 bed hospital. Object to secure a medical practice group. Central location within commuting distance of Springfield—60 miles, Decatur 35 miles & St. Louis 115 miles. Located on large lake recreational area. Contact: John Snyder, Shelby County Memorial Hospital, 1st & Cedar Sts., Shelbyville, 62565, 217-774-3961. (10)

**SPRINGFIELD**: Emergency Room Physician, Join 4 permanent staff physicians at a progressive 580 bed general hospital in Central Illinois. Attractive salary and benefits. Enjoy the relaxed atmosphere in this 92,000 population city. Practice medicine without the worries of office employees and accounting. Contact Arthur Lindsay, M.D. Memorial Medical Center, 1st and Miller Streets, Springfield, Illinois 62705. 217-528-2041. (12)

**SPRINGFIELD**: Emergency Room Physician, Join 4 permanent staff physicians at a progressive 580 bed general hospital in Central Illinois. Attractive salary and benefits. Enjoy the relaxed atmosphere in this 92,000 population city. Practice medicine without the worries of office employees and accounting. Contact Arthur Lindsay, M.D. Memorial Medical Center, 1st and Miller Streets, Springfield, Illinois 62705. 217-528-2041. (1)

## Chiropractic study slated

An agenda for a study of chiropractic was prepared early this month by a planning committee of neuroscientists, biomechanics specialists, chiropractors, and medical investigators. The study will be conducted primarily under the auspices of the National Institute of Neurological Diseases and Stroke.

The study was called for early this year when Congress passed a Health, Education, and Welfare Dept. appropriations bill after chiropractic coverage had been included in Medicare.

The broad study of the fundamentals of chiropractic will culminate in an international scientific conference in February, devoted to discussion of the research status of spinal manipulation.

At the time the study was proposed, H. Thomas Ballantine, M.D. chairman of the AMA Committee on Quackery, said he hoped it would determine "once and for all whether chiropractic is the valid 'separate and distinct' health care system it claims to be."

(*AMA News*, Aug. 1974)

# Obituaries

**\*\*Berry, Roy**, Lebanon, died July 28 at the age of 88. Dr. Berry was a past president of the Madison County Medical Association and a past treasurer and trustee of McKendree College in Lebanon.

**\*Berwanger, Willard**, Glen Ellyn, died July 31 at the age of 71. He graduated from the University of Wisconsin in 1929.

**\*Champagne, Carl**, Oak Park, died July 19 at the age of 71. He graduated from Loyola University in 1928. Dr. Champagne was a staff physician at Mother Cabrini Hospital for 42 years.

**\*Cohen, Abraham**, Peoria, died June 30 at the age of 70. Dr. Cohen graduated from the University of Illinois in 1928. He was a past president of the Methodist Hospital Medical Staff. He also served on the Boards of the Florence Critton Home and Crippled Childrens Center.

**\*Coogan, Thomas**, Chicago, died June 28 at the age of 73. He graduated from the St. Louis University School of Medicine in 1927. He served as a member of the staff of St. Luke's Medical Center. Dr. Coogan also served as physician to Mayor Daley before succeeded by his son. Dr. Coogan was associated with the University of Illinois Medical Center and served on the faculty of the Northwestern University School of Medicine.

**\*Frank, William W.**, Hinsdale, died July 2 at the age of 72. He graduated from the College of Medical Evangelists in 1927. Dr. Frank had been on the staff for 46 years at the Hinsdale Hospital.

**\*\*Heyman, Bernard**, Peoria, died July 7 at the age of 77. Dr. Heyman graduated from General Medical College in 1924. He practiced medicine for more than 50 years. Dr. Heyman was also also a surgeon and active on the medical staff of Proctor Hospital.

**\*Higgins, Melvin**, Harvey, died July 5 at the age of 62. He graduated from Rush Medical College in 1938. Dr. Higgins has been a general practitioner in Harvey for 35 years.

**\*Hopers, Anthony**, Western Springs, died July 4 at the age of 80. He graduated from the University of Illinois in 1922.

**\*Kowalski, Leonard**, Melrose Park, died July 21, at the age of 56. He graduated from Loyola University Stritch Medical School in 1943. Dr. Kowalski was a former head of the anesthesiology department at Mercy and Holy Cross Hospital.

**\*Mills, Morton**, Olympia Fields, died June 26 at the age of 75. Dr. Mills has been a general practitioner for over 50 years. He graduated from the University of Illinois in 1924.

**\*Trammel, Henry**, Chicago, died July 27 at the age of 81. Dr. Trammel received a degree in medicine from Northwestern University in 1918. He also practiced medicine at the Kansas City, Mo. General Hospital and was an attending physician at Provident Hospital for 40 years.

**\*\*Slobe, Frederick**, Florida died July 19 at the age of 81. He graduated from Rush Medical School in 1917. Dr. Slobe was a past president of the Industrial Medical Association, Fellow American College of Surgeons and the International College of Surgeons. He was also a former Chairman of the Illinois Board of Mental Health Commissioners.

**\*Wolf, Glenn**, Naperville, died July 17 at the age of 60. He graduated from the University of Illinois in 1949. Dr. Wolf was a founder of the Edward Hospital and Wolf Medical Group and president of the DuPage County Tuberculosis Center and Treatment Board.

**\*Indicates ISMS member**

**\*\*Indicates ISMS member and Fifty Year Club member**

## Canada Limits Liability Suits

The Canadian Supreme Court has handed down a landmark decision that makes medical malpractice suits invalid in that country if not filed within a year after injuries are suffered.

The unanimous judgment was rendered in an appeal by a Quebec hospital of a \$20,000 damage award to a woman who had suffered x-ray burns in 1960.

Previously, it was the opinion of the Canadian courts that a plaintiff had 30 years to file suit against a doctor or hospital. The Canadian court system, however, historically has favored the medical profession in malpractice suits, so this latest ruling, legal experts say, does not come as a complete surprise. The typical physician in Canada rarely is threatened by a malpractice suit and pays only about \$50 a year for malpractice insurance.

In handing down the ruling, the Supreme Court pointed out that the 30-year concept had been based on the view that the legal relationship between a physician or hospital and a patient produced an implied contract to provide proper medical care. The Supreme Court, however, held that malpractice suits should fall under the category of personal injury rather than breach of contract. And, in ordinary personal injury suits in Canada, legal action must be filed within a year.

The new ruling is expected to result in the dismissal of many suits now pending in Canadian courts.

(AMA News, Aug. 12, 1974)

# CLASSIFIED ADVERTISING

## Positions & Practice Opportunities

**IMMEDIATE FAMILY PRACTICE OPENING**—in two man clinic. Libertyville, Illinois, 35 miles northwest of Chicago. Initial salary and early partnership. Busy practice in small suburban town. Call collect—Dr. Lawrence C. Day (312) 362-1447.

**ATTENTION PHYSICIANS! CHICAGO MEDICAL CENTERS**—Welfare area in need of physicians. Please contact: Mr. Robert Fields (312) 236-2555.

**GENERAL INTERNISTS and GENERALISTS:** For growing sub-sections of 45 man medical department, including allergists, psychiatrists, neurologists, all sub-specialties and expanding primary care section. Multispecialty group of 120. Large patient population and area referral. Functioning HMO. Generous salary and fringe benefits. Peaceful setting near Wisconsin vacationland and cities. Good schools, cultural advantages, Junior College. Educational and research programs. Liberal schedules, little practice pressure. New Clinic and hospital developing. Write or call J. L. Struthers, M.D., Marshfield Clinic, Marshfield, Wisconsin 54449.

Immediate opening for **Ob-Gyn** and **Internal Medicine**, specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

**WHY FIGHT PSRO's, HMO's, AND ILLINOIS PUBLIC AID?** Join us—minimal records, short hours, 5 weeks vacation, and 1 week medical meetings. Illinois University Retirement System, Health Insurance, and Life Insurance. Beginning salary \$25,000 and negotiable. Call or contact Director, Health Service, EIU, Charleston, Illinois. Phone 217-581-3013.

**FAMILY PRACTICE AVAILABLE** about Sept. 1, 1974. Excellent set up with high earnings. Western suburb of Chicago. Write to Box 834 c/o Illinois Medical Journal, 360 N. Michigan, Chicago, Illinois, 60601.

**EXPERIENCED, BUSY G. P.** seeking regular hours. Will consider a clinic, hospital E. R. or other. Write Box 833 c/o Illinois Medical Journal, 630 N. Michigan, Chicago, Illinois 60601.

**CASHMERE, WASHINGTON FAMILY PRACTICE** opportunity in two-man office with four doctor week-end rotation. Scenic setting in orcharding valley on east edge of Cascades. Choice mountain and lake recreation and skiing. Vital community with quality schools. Excellent hospital facilities and cultural advantages in nearby Wenatchee. E. A. Meyer, M.D. (Iowa '50) ABFP, 303 Cottage Avenue, Cashmere, Wash. 98815. Tel.: (509) 782-1541.

**EMERGENCY ROOM PHYSICIAN**—Need fifth man to join four full-time physicians interested in acute care medicine. Regular hours, excellent fringe benefits, salary negotiable. 410-bed hospital (community), Medical School affiliation. ER group incorporation under consideration. Contact: John Edmundson, V.P. Administration, Rockford Memorial Hospital, 240 North Rockton Avenue, Rockford, Illinois 61101.

**FAMILY PHYSICIANS**—Unique practice opportunity in an incorporated 28 man group in east central Wisconsin. New clinic facility across the street from 450 bed hospital. Ideal cultural and recreational setting. Opportunity to develop special interests in acute and ongoing adult care and/or industrial medicine. Equal stockholder in one year. Excellent pre-tax fringes. Write Box 836, Illinois Medical Journal, 360 N. Michigan, Chicago, Ill. 60601.

**Large physician group has immediate positions available** for full-time or part-time Clinic and Emergency Room work. Several locations in Chicago and Central Illinois. Salary plus liberal benefits average over \$20.00 per hour for full-time work. Scheduling flexible to meet individual needs. Contact Gene Gaertner, M.D., 153 W. Lake, Bloomingdale, Ill. 312-627-3404.

**Full Time Medical Officers** Major Chicago-area hospital has immediate opening for General Practitioners and other specialists; Joint Commission accredited Medical Center; attractive benefits; competitive salary; all shifts available (8-4; 4-12; 12-8); Medical coverage needed for acute care, rehabilitation, skilled nursing and intermediate care levels; Excellent opportunity for professional advancement. Send curriculum vitae to: Ms. T. Higgins, Personnel Manager, Oak Forest Hospital, 15900 South Cicero Avenue, Oak Forest, Illinois 60452.

**VACANCY**—Admitting, primary care, personnel physician. Desire physician interested in academic university affiliation, preferably board certified in family practice. Five day week, nites free. VA benefits and retirement. Salary \$26,000 to \$32,000 depending on qualifications. Nondiscrimination in employment. Inquire: Chief of Ambulatory Care, VA Hospital, Iowa City, Iowa 52240. (Phone 319-338-0581).

**GYNECOLOGY CLINIC PHYSICIAN** for large university health service. Primarily office gynecology and family planning practice. Must have residency or extensive experience in specialty. No obstetrics or major surgery. Must be interested in preventive medicine and health education activities and programs and in working with college students. Illinois license required. Start anytime between August 1974 and January 1975. Equal Opportunity Employer. L. W. Akers, M.D., Director, UHS, N.I.U., DeKalb, Illinois 60115.

**PRIMARY CARE PHYSICIAN** for large university health service. Excellent facilities, liberal fringe benefits, good geographic location. Illinois license required. Equal Opportunity Employer. L. W. Akers, M.D., Director, UHS, N.I.U., DeKalb, Illinois 60115.

**INTERNIST**—To serve as Chief of Clinical Medicine for large university health service. Must be interested in new health care delivery systems, preventive medicine, health education, as well as clinical and consultative work. Illinois license required. Equal Opportunity Employer. L. W. Akers, M.D., Director USH, N.I.U., DeKalb, Illinois 60115.

**PHYSICIAN FOR ACUTE ILLNESS DEPARTMENT** and Emergency Room. Become a part of an expanding, dynamic multispecialty clinic in Midwest university community. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, Illinois 61801. Phone (217) 337-3239.

**NEWBERRY**—(Luce County)—Needed, general practitioners in beautiful Upper Peninsula Hospital, 60 miles west of the Mackinac Bridge. A fully accredited hospital with an excellent staff. New Medical Arts Building recently constructed. Excellent opportunity to start a practice. For a good place to live and bring up children, come to Newberry Michigan. Fringe benefits available.  
**CONTACT:** D. J. Massoglia, Helen Newberry Joy Hospital, Newberry, MI. 49868. Phone (906) 293-5181.

## FOR SALE, LEASE OR RENT

**BARRINGTON, ILL.**: Medical suites available in a newly completed multi-specialty Center just a few blocks from the future Good Shepherd Hospital. Ample paved parking facing Hwy. 14. All suites are 800 sq. ft., luxuriously finished, and absolutely independent. Call: (312) 381-4160 or 381-5800, or write to Box 829, c/o Illinois Medical Journal, 360 North Michigan Ave., Chicago, Ill. 60601.

**OFFICE FOR RENT**: Suitable for psychiatrist or psychotherapist. Contact: Dr. Gamm, c/o C. Swartz, 532 Pleasant, Highland Park, Ill., 60035, 433-0819, or call Ans. Serv. at (312) 787-7480. @ \$150/mo. located at 664 N. Michigan Ave., Chicago.

**HOUSE, OFFICE, EQUIPMENT, and FAMILY PRACTICE**, for sale in Chicago southwestern suburb. Affiliation with fine hospitals. Practice grosses \$100,000 plus, per year. Office building 1300 square feet, four (4) examining rooms. Separate, well-appointed 100-year old Victorian house, beautifully landscaped. Call collect (312) 485-1248.

**VACATION ON SANIBEL ISLAND, FLORIDA**. Luxurious condominium on Gulf Beach; two bedrooms, two baths, sleeps six; air-conditioned, pool, porch; minimum rental one week. Box 194, Ann Arbor, Michigan 48108.

**FOR RENT 4010 W. MADSON STREET—OFFICE SPACE** available for Medical Doctors. No need to buy a practice. We have plenty of patients for you. 1-2-3 Room Suites. Immediate Possession. Call: Illinois Property Management Corp., Mr. R. M. Ryan, Agent, 312-VA 6-4438 or 379-1133.

**12 ROOMS**—Suitable for doctors' offices, laboratory, dentists, etc. Available immediately. 55 East Washington. 332-2072.

**KEY BISCAYNE, FLA.**—lux. 1 bdrm. oceanfront condo, accom. 4 people, color T.V., marbled 1½ baths, balcony overlooking pool and beach, sauna, tennis, Golf course, shopping one block away 15 min. to Miami Beach & airport. V.P. Tumasonis M.D. 2454 W. 71st str., Chgo., Ill. 60629, 434-2123.

**MEDICAL OFFICES AVAILABLE**  
New — Reasonable — Air Conditioned. Sufficient Office Space for clinic potential. Good Area — Close to Hospitals — Southwest. Call Mr. Kaufman or Mr. Orzoff. 252-2300.

**3333 W. PETERSON MEDICAL & DENTAL BUILDING**—5 room suite available, divided into examining rooms, consultation room, secretarial & lab space, handsome reception room with receptionist service available. Immediately available. Phone IR 8-8785.

## MEDICAL ARTICLES FOR SALE

**NEED EQUIPMENT or SUPPLIES?** Your new examining rooms are in stock: Otoscopes, ophthalmoscopes, blood pressure equipment, stethoscopes, electrocardiographs, ultra sound, examining tables, surgical instruments, lamps, microscopes, hyfrecators, diatherms, paper gowns, drape sheets, paper towels, dressings, centrifuges, autoclaves, hemoglobinometers, syringes & needles, table paper, sutures, plastic gloves, oxygen, leather goods, scales, fracture appliances, pregnancy tests, laboratory supplies, audiometers. For Free **DISPOSABLES CATALOG** write or call: THE PHYSICIANS MART, 5637 West North Avenue, Chicago, Illinois 60639, Telephone: (312) 237-5343.

# BLUE SHIELD REPORT



## FOR Illinois Physicians

### Blue Shield States Position on NHI

*Portions of a statement delivered by Mr. Ned F. Parish, President of the National Association of Blue Shield Plans, before the Ways and Means Committee of the U. S. House of Representatives on May 31, 1974, are reprinted here. Speaking out for the 71 Blue Shield Plans which protect 72 million private subscribers and serve an additional 12 million persons thru government programs, Mr. Parish defended the private system of medical care prepayment as opposed to nationalized health insurance.*

*In his statement he cited examples of how Blue Cross and Blue Shield are conducting progressive programs in the health care field and emphasized that any federal action taken on health insurance should include a working partnership with the private insurance sector:*

"Mr. Chairman, we have been constructive in the past and we expect to continue to be. While the Congress considered Health Maintenance Organizations for four years, Blue Cross and Blue Shield were building them. While the Administration labors to implement Professional Standards Review Organizations, we are actively trying to help. The National Association and its member Plans are developing uniform accounting systems, utilization review programs, local pricing of services for out-of-state subscribers, and other technical advances to strengthen our system. With Blue Cross, we have spent millions of dollars in the past several years to develop uniform systems capable of handling, with increased efficiency, the substantially larger claims volume that can be expected from a major national priority on improved health financing. We have spent additional millions on containing health care costs, and on educating the public to care for its own health.

"The role of the private carrier in America has been absolutely unique in the world. No other country has developed the strong viable private insurance system that America has created.

"Blue Shield has in the past and again asserts that there are significant problems that private carriers have not been able to solve. Some of them can never be resolved without the active participation of government. We have been on record for almost four years as believing that a closer working partnership is needed between the insurance industry and the government. However, we want to emphasize the concept of partnership—of working together—as the logical and most productive course. Preemption of the industry would create more problems than it would solve.

"Some federal action is clearly necessary. We

believe it should proceed in a working partnership with our industry and in accord with a few basic principles, which we would suggest as:

"1. There should be maximum participation by the private sector, which has developed nearly all of the capacity which now exists in the actual administration of health benefits. To get the greatest benefit from the health financing industry, excessive regulation and controls not directed at quality and efficiency of coverage should be avoided at all costs.

"2. There should be free choice between provider and patient, and a competitive market among carriers, within the constraints of standards for benefits and administration.

"3. The public should have free choice of health care delivery systems.

"4. Federal financing will be required for coverage of the poor and the medically indigent. The private sector has no capacity to provide such financing without legislation.

"5. Effective regulation of carriers with respect both to benefits and retentions is necessary. Traditionally, this has been a state function, and regulations should continue to be implemented by the states. However, federal guidelines will be needed, and the federal government should have intervention authority if the states fail to act.

"6. There should be minimum standards for basic coverage, and an opportunity for groups and individuals who wish protection beyond the minimum level to purchase complementary coverage.

"7. There should be opportunity to integrate supplemental coverage with the basic coverage and administer it as one program, for economy and efficiency, and in order to provide first dollar benefits and the advantages of physician participation as an alternative to cost sharing through co-insurance and deductibles.

"8. Catastrophic coverage must be coordinated with basic coverage and should not be implemented as a 'free standing' program. In the absence of such coordination, it is essentially impossible to define the point of catastrophe, and there is potential for enormous duplication of administrative effort.

"9. An NHI program should be understandable from the outset in terms of its systems requirements, in order to facilitate design of appropriate systems for its implementation. However, implementation should be phased in, with maximum possible lead time, to permit orderly accommodation of the staffing, training, software and hardware problems which will accompany implementation, and which would be considerably exacerbated by a sudden massive eligibility for new benefits."

## LIMITATION ON LIABILITY OF BENEFICIARY AND PHYSICIAN

A new section of the Medicare Act entitled "Limitation on Liability of Beneficiary and Physician" contains provisions on furnishing Part B services and supplies under an assignment agreement after October 30, 1972. Either liability for payment is assessed or waiver of liability allowed in Part B assigned claims because the services or items furnished were determined by the carrier to be "not reasonable or necessary or custodial."

Frequently referred to as the "Waiver of Liability Provision" of the Medicare Act, regulations implementing the provision were made effective in November, 1973 upon issuance of an Intermediary Letter to Part B carriers by the Department of Health, Education and Welfare, Social Security Administration.

Before publication of the final regulations in the National Register, a brief summary of the interim instructions contained in the Intermediary Letter was published in the February 1974 issue of "Ask Blue Shield About Medicare", Illinois Medical Journal. A more comprehensive summary of the provisions is published herewith as information to the general medical community. Because of its length the summary will be published in successive issues of IMJ.

### INTRODUCTION

Three basic aspects of Section 1879 of the Medicare Act determine whether the liability of a beneficiary will be limited or waived in Part B denial cases involving services of physicians and suppliers:

(A) The denial is made because services rendered after October 30, 1972 are, under Medicare provisions, *not reasonable and necessary or constitute custodial care*;

(B) Payment is sought by the physician or supplier of services in *an assignment agreement*; and

(C) The beneficiary did not or could not reasonably have been expected to know that the services *are not covered*.

Where the liability of the beneficiary is limited because these conditions exist, the Medicare program will accept liability, i.e. make payment for the denied items or services, provided the *physician or supplier of services did not know and could not reasonably be expected to have known* that payment for the items or services would not be made. If the physician or supplier had or could be expected to have had such knowledge, liability would not be waived. In any event, if the beneficiary knew or could be expected to have known that the services *would not be considered reasonable or constituted custodial care, the ultimate liability will rest with the beneficiary, as well as the responsibility for payment to the physician or supplier*.

### II. Determination of Services Not Reasonable and Necessary

The new section of the Medicare Act provides for implementation of the waiver of liability issue *only when claim denials are made for reasons that*

"services and items are not reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member, or for custodial care".

The category of reasons for denial is apart from denials made under general Medicare exclusions.

When a claim is denied by the carrier for reasons of "not reasonable or necessary," but qualifies for review and hearing under the new section of the law, it must also be for a service or item that does not fall outside Medicare coverage.

Some items and services are denied as not reasonable because their medical effectiveness has not been established for diagnosis or treatment of any kind of illness, injury or medical condition. Examples of such procedures would be colonic irrigation and cellular therapy.

Other services and items may be recognized as effective in some circumstances but not in a particular case for certain conditions. An example would be a physician's daily visits to a patient's home. Such visits might be reasonable and necessary for one patient but not covered for another when the diagnosis and condition does not medically warrant daily visits.

*The waiver provision does not apply to denied claims for medically unreasonable or unnecessary services or items when payment would be denied under another exclusion or an unmet coverage requirement.* The following are examples of services or items that *do not come under the waiver of liability provisions*:

(A) Personal Comfort Items: those within the category of items that do not meet the definition of durable medical equipment and cannot be covered even though they may seem medically necessary because of the patient's condition. In some instances, items that are classified as durable medical equipment may be denied as not reasonable and necessary for a particular illness or injury and such denials *may be considered* for waiver of liability. Where liability is waived for durable medical equipment, the provision applies to rental for past periods or installments paid in those periods when the item was purchased;

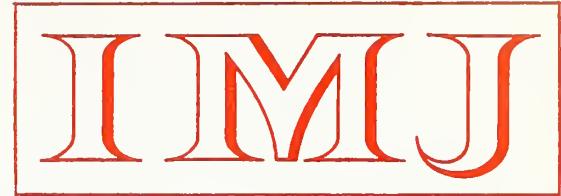
(B) Routine physical checkups, eyeglasses, eye examinations for the purpose of prescribing, fitting or changing eyeglasses, procedures to determine refractive state of the eyes, hearing aids or examination of hearing aids, or immunizations. (*Those services and items generally excluded under the program*);

(C) Cosmetic surgery, or expenses incurred in connection with such surgery;

(D) Services in connection with care, treatment, filling, removal or replacement of teeth or structures directly supporting teeth;

(E) Failure to meet a condition—such as drugs and biologicals that can be self-administered, unnecessary ambulance services, ambulance services partially denied because the trip exceeds covered limits.

— CONTINUED IN NOVEMBER ISSUE —



## Illinois Medical Journal

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OCTOBER, 1974

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**IMPORTANT INFORMATION:** This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalnline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

**Indications:** Lomotil is effective as adjunctive therapy in the management of diarrhea.

**Contraindications:** In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

**Warnings:** Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate

HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

**Usage in pregnancy:** Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

**Precautions:** Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

**Adverse reactions:** Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritis, angioneurotic edema, giant urticaria and paralytic ileus.

**Dosage and administration:** Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For

ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonsfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

**Overdosage:** Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

**Dosage forms:** Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

**SEARLE**

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Medical Department, Box 5110,  
Chicago, Illinois 60680

# Editorials



## Peptic Ulcer: Diet or Drugs?

A quiet revolution has been going on among physicians who treat various gastrointestinal diseases. Many of our traditional concepts based on the need for dietary treatment of peptic ulcer disease have not held up when examined meticulously under controlled scientific conditions.

Much of the controversy has to do with the fact that some foods are, by reputation, irritating, and others, soothing to the gastrointestinal tract. It is wrong to assume that the form, color, consistency, taste, or aroma of a certain food could have any effect on gastrointestinal secretions, motility, or the mucosal lining. Yet, no one is willing to say that a specific food is chemically and mechanically helpful, or detrimental.

Milk, for example, stimulates acid production, but milk also has a buffering effect. Perhaps milk neutralizes the acid it produces in the stomach.

According to a recent report, corn flakes and butter are probably ideal because they stimulate very little acid. Yet, each has considerable ability to neutralize acidity.

Some physicians feel that antacids and anti-cholinergic drugs are better than a diet in the treatment of ulcer. I overheard a gastroenterologist say that he tells his patients to eat what they want, but not to smoke cigarettes or drink alcohol or coffee. He relies on antacids, but tells his patients to avoid foods that they tolerate poorly. This man believes, however, that his patients should enjoy their food.

Revolutionary changes also have been going on in the management of irritable bowel and diver-

ticular disease.

Today, the high-residue diet, rather than the time-honored low-residue diet, is being advocated. The rationale is that diets high in vegetables, fruits, and meat fiber pass more rapidly through the intestine, and do so with less difficulty. With greater stool weights, constipation is less likely to occur and the digesting food has less time for bacterial and enzymatic production.

Soft, carbohydrate bulk-less foods tend to linger in the bowel and promote constipation. This, in turn, leads to strong muscular contractions and increased internal pressure. Roughage encourages a swiftly-passed stool, which subjects the colon to less strain and does not favor diverticular development. The pockets seldom make a fuss unless their openings are blocked or they become inflamed. Antispasmodic drugs ease the cramping; antibiotics or sulfonamides control the infection.

In contrast, diet is important in patients with celiac sprue. They do best on a gluten-free diet. A lactose-free diet helps those suffering from congenital malabsorption of lactose. Substitution of fructose for all sources of glucose and galactose can be life-saving for infants lacking the intestinal mechanism for monosaccharides transport.

Individuals who have idiosyncrasies to certain foods should avoid eating whatever does not agree with them.

T. R. Van Dellen, M.D.  
*Editor*

# The overweight diabetic... trapped by her own fat cells.

If only she would diet, her blood sugar might come down. Her high levels of blood insulin might come down, too. This may be important in the overweight diabetic since insulin is the "storage hormone" that transports glucose into adipose tissue. Maybe the last thing the overweight diabetic needs to lower her blood sugar is a drug that stimulates more insulin secretion.

If dieting doesn't work in the overweight, nonketotic, adult-onset diabetic, consider adding DBI-TD.

**DBI-TD® Geigy**  
phenformin HCl

Lowers blood sugar without  
raising blood insulin.



**DBI® phenformin HCl** Tablets of 25 mg.

**DBI-TD® phenformin HCl**

Timed-Disintegration Capsules of 50 and 100 mg.

**Indications:** Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary, adjunct to insulin therapy of unstable diabetes mellitus.

**Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); after disease states associated with hypoxemia.

**Warnings:** Use during pregnancy is to be avoided.

**Precautions:** 1. Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result

from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state.

**Do not give insulin without first checking blood and urine sugar.**

2. Lactic Acidosis: This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. Hypoglycemia: Although hypoglycemic re-

actions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

**Adverse Reactions:** Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.

(B) 98-146-103-E (6/72)

*For complete details, including dosage, please see full prescribing information.*

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## Clinics for Crippled Children Listed for November

Twenty-nine clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 22 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Nov. 4 Peoria Cardiac—St. Francis Children's Hospital
- Nov. 5 Belleville—St. Elizabeth's Hospital
- Nov. 6 Hinsdale—Hinsdale Sanitarium
- Nov. 7 Sterling—Sterling Community Hospital
- Nov. 7 Effingham—St. Anthony Memorial Hospital
- Nov. 7 Lake County Cardiac—Victory Memorial Hospital
- Nov. 7 Springfield—St. John's Hospital
- Nov. 8 Chicago Heights Cardiac—St. James Hospital
- Nov. 12 Peoria—St. Francis Children's Hospital
- Nov. 12 East St. Louis—Christian Welfare Hospital
- Nov. 12 Rock Island—Moline Public Hospital
- Nov. 13 Champaign-Urbana—McKinley Hospital
- Nov. 13 Joliet—St. Joseph's Hospital
- Nov. 14 Pittsfield—Illini Hospital
- Nov. 14 W. Frankfort—Union Hospital
- Nov. 14 Macomb—McDonough District Hospital
- Nov. 19 Decatur—Decatur Memorial Hospital
- Nov. 19 Fairfield—Fairfield Memorial Hospital
- Nov. 20 Rockford—St. Anthony Hospital
- Nov. 20 Centralia—St. Mary's Hospital
- Nov. 20 Springfield Pediatric-Neurology—Diocesan Center
- Nov. 20 Evergreen Park—Little Company of Mary Hospital
- Nov. 21 Elmhurst Cardiac—Memorial Hospital of DuPage County
- Nov. 22 Chicago Heights Cardiac—St. James Hospital
- Nov. 25 Peoria Cardiac—St. Francis Children's Hospital
- Nov. 26 Peoria—St. Francis Children's Hospital
- Nov. 26 Alton—Alton Memorial Hospital
- Nov. 27 Elgin—Sherman Hospital
- Nov. 27 Chicago Heights—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children. □

### PROLOID® (thyroglobulin)

**Caution:** Federal law prohibits dispensing without prescription.

**Description.** Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine ( $T_4$ ) and Sodium Liothyronine ( $T_3$ ). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of  $T_4$  and  $T_3$  in Proloid (thyroglobulin) is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

**Indications.** Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in non-emergency situations, in an attempt to reduce the size of such goiters.

**Contraindication.** Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

**Warnings.** Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

**Precaution.** As with all thyroid preparations this drug will alter results of thyroid function tests.

**Adverse Reactions.** Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

**Dosage and Administration.** Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR,  $T_3$ ,  $^{131}\text{I}$  resin sponge uptake,  $T_3$ ,  $^{131}\text{I}$  red cell uptake, Thyo Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of  $T_4$  and  $T_3$  is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

**Overdosage Symptoms.** Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive over-dosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

**How Supplied.**  $\frac{1}{4}$  grain;  $\frac{1}{2}$  grain; scored 1 grain;  $\frac{1}{2}$  grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

Full information available on request.



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**REFERENCE  
ISSUE**



# IMJ

*Illinois Medical Journal*

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## ISMS ORGANIZATION

### History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted; the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1958. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected as Executive Administrator in May, 1968.

The Society published the early transactions in

book form presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. Van Dellen is the editor today.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922 he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

# OFFICERS AND PLACES OF MEETING

| YEAR | PRESIDENT          | SECRETARY      | TREASURER       | Mtg. PLACE   | YEAR | PRESIDENT             | SECRETARY      | TREASURER       | Mtg. PLACE     |
|------|--------------------|----------------|-----------------|--------------|------|-----------------------|----------------|-----------------|----------------|
| 1840 | John Todd          | David Prince   |                 | Springfield  | 1896 | D. W. Graham          | J. B. Hamilton | Geo. N. Kreider | Ottawa         |
| 1850 | Rudolph Rouse      | Edwin G. Meek  |                 | Springfield  | 1897 | A. C. Corr            | J. B. Hamilton | Geo. N. Kreider | East St. Louis |
| 1850 | William B. Herrick | Edwin G. Meek  |                 | Springfield  | 1898 | J. N. G. Carter       | E. W. Weis     | Geo. N. Kreider | Galesburg      |
| 1851 | Samuel Thompson    | H. Shoemaker   | R. Rouse        | Peoria       | 1899 | J. T. Pitner          | E. W. Weis     | Geo. N. Kreider | Cairo          |
| 1852 | Rudolph Rouse      | E. S. Cooper   | Edw. Dickenson  | Jacksonville | 1900 | H. N. Moyer           | E. W. Weis     | Geo. N. Kreider | Springfield    |
| 1853 | Daniel Brainerd    | H. A. Johnson  | A. B. Chambers  | Chicago      | 1901 | G. N. Kreider         | E. W. Weis     | E. J. Brown     | Peoria         |
| 1854 | C. N. Andrews      | H. A. Johnson  | N. S. Davis     | LaSalle      | 1902 | J. T. McAnally        | E. W. Weis     | Quincy          | Quincy         |
| 1855 | N. S. Davis        | E. Andrews     | J. V. Z. Blaney | Bloomington  | 1903 | M. L. Harris          | E. W. Weis     | E. J. Brown     | Chicago        |
| 1856 | H. Noble           | N. S. Davis    | J. V. Z. Blaney | Vandalia     | 1904 | C. E. Black           | E. W. Weis     | E. J. Brown     | Bloomington    |
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| 1858 | H. A. Johnson      | N. S. Davis    | J. W. Freer     | Rockford     | 1906 | H. C. Mitchell        | E. W. Weis     | E. J. Brown     | Springfield    |
| 1859 | David Prince       | N. S. Davis    | J. W. Freer     | Decatur      | 1907 | J. F. Percy           | E. W. Weis     | E. J. Brown     | Rockford       |
| 1860 | Wm. M. Chambers    | N. S. Davis    | J. W. Freer     | Paris        | 1908 | W. L. Baum            | E. W. Weis     | E. J. Brown     | Peoria         |
| 1863 | A. McFarland       | N. S. Davis    | J. H. Hollister | Jacksonville | 1909 | J. W. Pettit          | E. W. Weis     | E. J. Brown     | Quincy         |
| 1864 | A. H. Luce         | N. S. Davis    | J. H. Hollister | Chicago      | 1910 | J. L. Wiggins         | E. W. Weis     | E. J. Brown     | Danville       |
| 1865 | J. M. Steele       | N. S. Davis    | J. H. Hollister | Bloomington  | 1911 | A. C. Cotton          | E. W. Weis     | E. J. Brown     | Aurora         |
| 1866 | F. F. Haller       | N. S. Davis    | J. H. Hollister | Decatur      | 1912 | W. K. Newcomb         | E. W. Weis     | E. J. Brown     | Springfield    |
| 1867 | H. Noble           | N. S. Davis    | J. H. Hollister | Springfield  | 1913 | L. H. A. Nickerson    | E. W. Weis     | A. J. Markley   | Peoria         |
| 1868 | S. T. Trowbridge   | N. S. Davis    | J. H. Hollister | Quincy       | 1914 | Charles J. Whalen     | W. H. Gilmore  | A. J. Markley   | Decatur        |
| 1869 | S. T. Trowbridge   | T. D. Fitch    | J. H. Hollister | Chicago      | 1915 | A. L. Brittin         | W. H. Gilmore  | A. J. Markley   | Springfield    |
| 1870 | J. V. Z. Blaney    | T. D. Fitch    | J. H. Hollister | Dixon        | 1916 | C. W. Lillie          | W. H. Gilmore  | A. J. Markley   | Champaign      |
| 1871 | G. W. Albin        | T. D. Fitch    | J. H. Hollister | Peoria       | 1917 | W. L. Noble           | W. H. Gilmore  | A. J. Markley   | Bloomington    |
| 1872 | J. O. Hamilton     | T. D. Fitch    | J. H. Hollister | Rock Island  | 1918 | E. B. Coolley         | W. H. Gilmore  | A. J. Markley   | Springfield    |
| 1873 | D. W. Young        | T. D. Fitch    | J. H. Hollister | Bloomington  | 1919 | E. W. Fiegenbaum      | W. H. Gilmore  | A. J. Markley   | Peoria         |
| 1874 | T. F. Worrell      | T. D. Fitch    | J. H. Hollister | Chicago      | 1920 | J. W. Van Derslice    | W. H. Gilmore  | A. J. Markley   | Rockford       |
| 1875 | J. H. Hollister    | T. D. Fitch    | Wm. E. Quine    | Jacksonville | 1921 | W. F. Grinstead       | W. H. Gilmore  | A. J. Markley   | Springfield    |
| 1876 | T. D. Washburn     | N. S. Davis    | J. H. Hollister | Urbana       | 1922 | Charles Humiston      | W. H. Gilmore  | A. J. Markley   | Chicago        |
| 1877 | T. D. Fitch        | N. S. Davis    | J. H. Hollister | Chicago      | 1923 | E. P. Sloan           | W. D. Chapman  | A. J. Markley   | Decatur        |
| 1878 | J. L. White        | N. S. Davis    | J. H. Hollister | Springfield  | 1924 | E. H. Ohsner          | W. D. Chapman  | A. J. Markley   | Springfield    |
| 1879 | E. P. Cook         | N. S. Davis    | J. H. Hollister | Lincoln      | 1925 | L. C. Taylor          | H. M. Camp     | A. J. Markley   | Quincy         |
| 1880 | Ephraim Ingalls    | N. S. Davis    | J. H. Hollister | Belleview    | 1926 | J. C. Kraft           | H. M. Camp     | A. J. Markley   | Champaign      |
| 1881 | G. W. Jones        | S. J. Jones    | J. H. Hollister | Chicago      | 1927 | Mather Pfeiffenberger | H. M. Camp     | A. J. Markley   | Moline         |
| 1882 | Robert Boal        | S. J. Jones    | J. H. Hollister | Quincy       | 1928 | G. Henry Mundt        | H. M. Camp     | A. J. Markley   | Springfield    |
| 1883 | A. T. Darrah       | S. J. Jones    | J. H. Hollister | Peoria       | 1929 | J. E. Tuote           | H. M. Camp     | A. J. Markley   | Chicago        |
| 1884 | E. Andrews         | S. J. Jones    | Walter Hay      | Chicago      | 1930 | F. O. Frederikson     | H. M. Camp     | A. J. Markley   | Peoria         |
| 1885 | D. S. Booth        | S. J. Jones    | Walter Hay      | Springfield  | 1931 | Wm. D. Chapman        | H. M. Camp     | A. J. Markley   | Joliet         |
| 1886 | Wm. A. Byrd        | S. J. Jones    | Walter Hay      | Bloomington  | 1932 | R. R. Ferguson        | H. M. Camp     | A. J. Markley   | East St. Louis |
| 1887 | Wm. T. Kirk        | D. W. Graham   | Walter Hay      | Chicago      | 1933 | John R. Neal          | H. M. Camp     | A. J. Markley   | Springfield    |
| 1888 | Wm. O. Ensign      | D. W. Graham   | Walter Hay      | Rock Island  | 1934 | Philip H. Kreuscher   | H. M. Camp     | A. J. Markley   | Peoria         |
| 1889 | C. W. Earle        | D. W. Graham   | T. W. McIlvaine | Jacksonville | 1935 | Charles D. Center*    | H. M. Camp     | A. J. Markley   | Springfield    |
| 1890 | John Wright        | D. W. Graham   | T. W. McIlvaine | Chicago      | 1935 | Charles S. Skaggs     | H. M. Camp     | A. J. Markley   | Rockford       |
| 1891 | Jno. P. Mathews    | D. W. Graham   | Geo. N. Kreider | Springfield  | 1936 | Chas. B. Reed         | H. M. Camp     | A. J. Markley   | Springfield    |
| 1892 | Charles C. Hunt    | D. W. Graham   | Geo. N. Kreider | Vandalia     | 1937 | Rolland L. Green      | H. M. Camp     | A. J. Markley   | Peoria         |
| 1893 | E. Fletcher Ingals | D. W. Graham   | Geo. N. Kreider | Chicago      | 1938 | R. K. Packard         | H. M. Camp     | A. J. Markley   | Springfield    |
| 1894 | Otho B. Will       | J. B. Hamilton | Geo. N. Kreider | Decatur      | 1939 | S. E. Munson          | H. M. Camp     | A. J. Markley   | Rockford       |
| 1895 | Daniel R. Brower   | J. B. Hamilton | Geo. N. Kreider | Springfield  |      |                       |                |                 |                |

(Continued on following page)

| YEAR | PRESIDENT            | SECRETARY       | TREASURER       | MIC. PLACE  |
|------|----------------------|-----------------|-----------------|-------------|
| 1940 | Jas. H. Hutton       | H. M. Camp      | A. J. Markley   | Peoria      |
| 1941 | J. S. Templeton      | H. M. Camp      | A. J. Markley   | Chicago     |
| 1942 | Chas. H. Phifer      | H. M. Camp      | H. M. Camp      | Springfield |
| 1943 | E. H. Weld           | H. M. Camp      | H. M. Camp      | Chicago     |
| 1944 | G. W. Post**         | H. M. Camp      | H. M. Camp      | Chicago     |
| 1945 | E. P. Coleman        | H. M. Camp      | H. M. Camp      | ***         |
| 1946 | E. P. Coleman        | H. M. Camp      | H. M. Camp      | Chicago     |
| 1947 | R. S. Berghoff       | H. M. Camp      | H. M. Camp      | Chicago     |
| 1948 | I. H. Neece          | H. M. Camp      | H. M. Camp      | Chicago     |
| 1949 | Percy E. Hopkins     | H. M. Camp      | H. M. Camp      | Chicago     |
| 1950 | Walter Stevenson     | H. M. Camp      | H. M. Camp      | Springfield |
| 1951 | Harry M. Hedge       | H. M. Camp      | H. M. Camp      | Chicago     |
| 1952 | C. Paul White        | H. M. Camp      | H. M. Camp      | Chicago     |
| 1953 | Leo P. A. Sweeney    | H. M. Camp      | H. M. Camp      | Chicago     |
| 1954 | Willis I. Lewis      | H. M. Camp      | H. M. Camp      | Chicago     |
| 1955 | Arkell M. Vaughn     | H. M. Camp      | H. M. Camp      | Chicago     |
| 1956 | F. Garm Norbury      | H. M. Camp      | H. M. Camp      | Chicago     |
| 1957 | F. Lee Stone         | H. M. Camp      | H. M. Camp      | Chicago     |
| 1958 | Lester S. Reavley    | H. M. Camp      | H. M. Camp      | Chicago     |
| 1959 | Raleigh C. Oldfield  | H. M. Camp      | H. M. Camp      | Chicago     |
| 1960 | Joseph T. O'Neill    | George F. Lull  | George F. Lull  | Chicago     |
| 1961 | H. Close Hesseltine  | Jacob E. Reisch | Jacob E. Reisch | Chicago     |
| 1962 | Edwin S. Hamilton    | Jacob E. Reisch | Jacob E. Reisch | Chicago     |
| 1963 | George F. Lull       | Jacob E. Reisch | Jacob E. Reisch | Chicago     |
| 1964 | Harlan English       | Jacob E. Reisch | Jacob E. Reisch | Chicago     |
| 1965 | Edward A. Piszczeck  | Jacob E. Reisch | Jacob E. Reisch | Chicago     |
| 1966 | Burtis E. Montgomery | Jacob E. Reisch | Jacob E. Reisch | Chicago     |
| 1967 | Caesar Portes        | Jacob E. Reisch | Jacob E. Reisch | Chicago     |
| 1968 | Newton DuPuy         | Jacob E. Reisch | Jacob E. Reisch | Chicago     |
| 1969 | Philip G. Thomesen   | Jacob E. Reisch | Jacob E. Reisch | Chicago     |
| 1970 | Edward W. Cannady    | Jacob E. Reisch | Jacob E. Reisch | Chicago     |
| 1971 | J. Ernest Breed      | Jacob E. Reisch | Jacob E. Reisch | Chicago     |
| 1972 | L. T. Fruin****      | Jacob E. Reisch | Jacob E. Reisch | Chicago     |
| 1973 | Frank J. Jirka, Jr.  | Jacob E. Reisch | Jacob E. Reisch | Chicago     |
| 1974 | Willard C. Scrivner  | Jacob E. Reisch | Jacob E. Reisch | Chicago     |
| 1975 | Frederic D. Lake     | Jacob E. Reisch | Jacob E. Reisch | Chicago     |

\*Died before induction into office

\*\*Died in office. Term completed by Robert S. Berghoff, First Vice President

\*\*\*\*Meeting cancelled 1945

\*\*\*\*Died in office. Term completed by C. J. Jennings, First Vice President

## **Principles Of Medical Ethics**

**PREAMBLE:** These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

**SECTION 1**—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

**SECTION 2**—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

**SECTION 3**—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

**SECTION 4**—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

**SECTION 5**—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving

adequate notice. He should not solicit patients.

**SECTION 6**—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

**SECTION 7**—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

**SECTION 8**—A physician should seek consultation upon request, in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

**SECTION 9**—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

**SECTION 10**—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

# Constitution And Bylaws

**Adopted, 1903  
As Amended, 1974**

## CONSTITUTION

### ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

### ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

### ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

### ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

### ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

### ARTICLE VI. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, nineteen trustees and one trustee at large, and such other officers as the Bylaws may provide.

### ARTICLE VII. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive and judicial, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

### ARTICLE VIII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates and general scientific meetings which shall be open to all registered members.

### ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

### ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual business meeting of the House of Delegates provided that the amendment shall have been proposed at the preceding annual business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

## BYLAWS

### CHAPTER I. MEMBERSHIP

Section 1. *Members.* Members shall consist of Regular members, Provisional members, Associate members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. *Regular Members.* Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are residents of the State of Illinois, persons of good moral character and professional standing and members of their component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

B. *Provisional Members.* Provisional membership shall be available to any Illinois physician who has made a declaration of intention to become a citizen of the United States, who has received a license in this

**I.** *Student Members.* Student members are those who have been accepted for the second year or higher in an Illinois medical school, are of good moral character, professional and academic standing and student members of a component medical society.

**Section 2. Discrimination of Membership.** Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion or ethnic origin.

**Section 3. Tenure and Termination.**

**A. Tenure of Membership.** The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be *prima facie* evidence of membership in this society. The member shall retain his membership so long as he complies with the provisions of this Constitution and Bylaws and with the Principles of Medical Ethics of the American Medical Association. A member shall hold only one type of membership at any one time.

**B. Termination of Membership.** Any person who is under sentence of suspension, or expulsion from a component society shall not be entitled to any of the rights or benefits of this society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Non-payment of dues by May 1 of each year shall be grounds for termination of membership.

**CHAPTER II. DUES, FUNDS AND ASSESSMENTS**

**Section 1. Dues.** Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal*. Only Regular, Provisional, Associate, In-training and Student members shall be assessed annual dues. The assessment shall be paid by the component society for its members prior to March 31 of each year.

**Section 2. Reduction and Remission of Dues.** Physicians in private practice of medicine may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

**Section 3. Assessments and Funds.** In addition to dues, assessments may be made on dues-paying members on recommendation of the Board of Trustees and approval of the House of Delegates. Funds may be raised from publications of the Society and any other manner approved by the Board of Trustees. Funds may be appropriated by the Board of Trustees to be spent for the Society to carry on its publications, to encourage scientific investigations, and for other purposes approved by the Board of Trustees.

**H. In-Training Members.** In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members, of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

### **CHAPTER III. EDUCATIONAL AND SCIENTIFIC PROGRAMS**

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

### **CHAPTER IV. HOUSE OF DELEGATES**

**Section 1. Composition.** The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies and affiliated groups, 2) the President, 3) the President-elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, and 7) Trustees. Past trustees, past presidents, past speakers, general officers of the American Medical Association, and delegates and alternate delegates from the Illinois State Medical Society to the American Medical Association may have the privilege of the floor without vote.

**Section 2. Delegates.** Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

**Section 3. Affiliate Group Delegates.** The combined Illinois chapters of the Student American Medical Association shall be considered a single affiliate group and shall be entitled to one student delegate with vote, and one student alternate delegate to serve in the House of Delegates. One intern/resident delegate with vote and an alternate delegate, representing the interests of Illinois house staff, shall be nominated by the Advisory Committee to Physicians in Training pursuant to appointment by the Board of Trustees. Each delegate shall be considered as an Affiliated Group Member of the Illinois State Medical Society. The term of office shall begin January first following his election and shall be for two years, or until his successor is elected.

**Section 4. Time and Place of Meeting.** The House of Delegates shall meet annually at such time and place as it shall determine.

**Section 5. Quorum.** Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

**Section 6. Special meetings.** Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting

shall not consider any business except that for which it was called.

**Section 7. Registration.** Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President and/or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

**Section 8. District Division.** The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

**Section 9. Order of Procedure.** The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

**Section 10. Privilege of the Floor.** The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

**Section 11. Introduction of Resolutions and Other Business.** All resolutions must be introduced by a voting member of the House. Resolutions to be printed in the handbook must be submitted nine weeks prior to the annual meeting. Resolutions to be mailed to the delegates prior to the annual meeting must be submitted to ISMS headquarters four weeks prior to the annual meeting. Resolutions submitted after the above date must be approved by the Speaker, Vice Speaker and one delegate from CMS and one from outside CMS or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. Reports of committees, councils and officers requiring action must submit recommendations to the House as a resolution for action. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

### **CHAPTER V. ELECTION OF OFFICERS**

**Section 1. Officers.** The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, nineteen trustees and one trustee-at-large.

**Section 2. Elections.** All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect. The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

**Section 3. Terms of Office.** The president-elect, vice-presidents secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become a trustee-at-large for a term of one year.

## CHAPTER VI. DUTIES OF OFFICERS

**Section 1. The President.** The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

**Section 2. The Vice Presidents.** The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, the second vice president will become first vice president.

**Section 3. Successor to President-Elect.** In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

**Section 4. The Speaker.** The speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be an ex-officio member of the Committee on Constitution and Bylaws.

**Section 5. The Vice Speaker.** The vice speaker shall preside for the speaker in the latter's absence or at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

**Section 6. The Secretary-Treasurer.** In addition to the rights and duties ordinarily devolving on the secretary

of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

## CHAPTER VII. THE BOARD OF TRUSTEES

**Section 1. Composition.** The Board of Trustees shall consist of: nineteen trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary treasurer. Nine trustees shall be chosen from District 3 and one from each of the other ten districts as defined on the geographical map of the state approved in May, 1946.

**Section 2. Duties.** The duties of the Board of Trustees are executive, custodial and judicial.

**A. Executive Duties.** The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

**B. Custodial Duties.** The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

C. *Judicial Duties.* The Board of Trustees shall be the board of censors of the Society. It shall have jurisdiction over all questions of ethics and in the interpretation of the laws of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to component societies, or to this Society.

All questions of an ethical nature before the House of Delegates or the general scientific meetings, shall be referred to the Board of Trustees without discussion. The Board shall hear and decide all questions of procedure affecting the conduct of members on which an appeal is taken from the decision of a component society.

The decision of the Board of Trustees shall be final except that an appeal may be taken by a member charged with misconduct as provided for in the Constitution and Bylaws of the American Medical Association.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice-president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

#### Section 5. *Organization.*

A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year.

B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board.

Section 6. *Quorum.* Ten members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publication.* The Board of Trustees shall provide and superintend the publication and the distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate bond for those

officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio members of all district committees. He shall report to the Board of Trustees the actions of the component societies on reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

## CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural

rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

## CHAPTER IX. COMMITTEES

**Section 1. Committee Structure.** The committee structure of the Illinois State Medical Society shall be as follows:

- A. Councils (standing committees)
- B. House of Delegates Committees
- C. Board of Trustees Committees
- D. Ethical Relations Committee (Chapter XI of these Bylaws)

### Section 2. Councils.

A. The Medical-Legal Council shall be concerned in the areas of:

- 1. Liaison with the Illinois Bar Association
- 2. Liaison with courts, particularly where impartial medical testimony is involved.
- 3. Implementation of the Impartial Medical Testimony Rule
- 4. Legal aspects of medical practice other than in the area of mental health
- 5. Licensing and standards of practice.
- 6. Quackery
- 7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in the areas of:

- 1. Federal and state legislation—analysis and communication
- 2. Legislative liaison—both state and federal
- 3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:

- 1. Liaison with medical schools, curricula, etc.
- 2. Health manpower and training
- 3. Internships, residencies, etc.
- 4. Scientific assembly
- 5. Student loans
- 6. Liaison with Student American Medical Association
- 7. Continuing Medical Education

D. The Council on Economics and Peer Review shall be concerned in the areas of:

- 1. Relations with governmental purchase of care programs (Medicare, Medicaid, Vocational Rehabilitation, etc.)

- 2. Relations with prepayment, insurance and other third party plans.
- 3. Fees and fee adjudication
- 4. Health care cost and utilization
- 5. Peer Review (Part 2 of Chapter XII of these Bylaws)

E. The Council on Environmental and Community Health shall be concerned in the areas of:

- 1. Governmental Departments of Health
- 2. Public Safety
- 3. Occupational Health
- 4. Child and School Health
- 5. Pollution
- 6. Nutrition
- 7. Maternal Welfare

F. The Council on Public Relations and Membership Services shall be concerned in the areas of:

- 1. Publicity and promotion
- 2. News media relations
- 3. Exhibits and public service programming
- 4. Religion and medicine
- 5. New member orientation and membership benefit explanation

G. The Council on Mental Health and Addiction shall be concerned in the areas of:

- 1. Facilities and services
- 2. Liaison with Department of Mental Health
- 3. Legal aspects of commitment, etc.
- 4. Narcotics and dangerous drugs
- 5. Alcoholism

H. The Council on Social and Medical Services shall be concerned in the areas of:

- 1. Health care facilities and services
- 2. Emergency and disaster care
- 3. Liaison with other health professional and health oriented organizations
- 4. Health care of the poor
- 5. Problems of aging
- 6. Rural health

I. The Council on Affiliate Societies shall be concerned in the areas of:

- 1. Liaison between the affiliate society and ISMS.
- 2. Scientific resource information and advice to ISMS.
- 3. Consultation to other councils, e.g., postgraduate education, health care delivery, publicity, legislation.
- 4. Advances of medical science in special fields.

### Section 3. Organization of Councils.

A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.

B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or pur-

poses assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.

C. Members of the Illinois State Medical Society (who are not voting members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by Illinois Chapters of the Student American Medical Association, or other recognized student organizations approved by the Illinois State Medical Society Board of Trustees to serve with Illinois State Medical Society members on appropriate committees, may by action of the Board of Trustees, be accorded membership in this classification for the term of the committee appointment. Such members shall be permitted full privileges of committee membership, including (with the permission of the House of Delegates) the right to speak on the floor of the House, but to have no vote out of committee. Voting members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils, and may attend all committee meetings.

F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.

G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.

H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the council under which they are operating.

Reports of council activities shall include recommendations on reports and requests from subcommit-

tees, and shall be made to the Board of Trustees by the chairman of the council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

#### J. Affiliate Societies

1. *Qualifications.* Affiliate societies shall be those recognized societies of Illinois

- a) as may be approved by the Board of Trustees
- b) which desire representation on the Council on Affiliate Societies

2. *Representation.* Each affiliate society shall be entitled to one member on the council. This representative shall be a member of ISMS.

Section 4. *House of Delegates Committees.* House of Delegates Committees of the Illinois State Medical Society shall be as follows:

A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.

B. Committee on Rules and Order of Business shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.

C. Committee on Tellers and Sergeants-at-Arms shall:

1. Serve the speaker of the House of Delegates.
2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
3. Certify those in attendance in closed or executive sessions of the House of Delegates.

D. Committee on Changes in the Constitution and Bylaws shall consider all proposed amendments to the Constitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.

F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economics activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

*Section 5. Organization of House of Delegates Committees.*

A. Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

*Section 6. Board of Trustees Committees.* The Board of trustees shall form the following committees within itself:

A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee.

The Board of Trustees may delegate to the executive committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions

of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

This committee shall also:

1. Examine applications to the Society for assistance under the Medical Benevolence to determine eligibility for assistance;
2. Keep the names of the beneficiaries confidential and known only to the committee;
3. Recommend the allotment for each recipient; and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. The Ethical Relations Committee shall be constituted and function as stipulated in Chapter XI, Discipline, Part 2, Illinois State Medical Society procedures.

E. The Committee on Constitution and Bylaws shall consist of five members of the Board appointed by the chairman and it shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

F. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal*.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal*.

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

G. The Advisory Committee to the Woman's Auxiliary shall consist of the president-elect as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

H. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

*Section 7. Powers of the Board of Trustees.* The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

*Section 8. Term of Membership.* The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

## CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Board of Trustees.

Section 6. When a member in good standing in a component society changes his residence to another county

in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving this application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

*Section 7.* A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

*Section 8.* The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

*Section 9.* The secretary of each component society shall forward its roster of officers and members, and a list of delegates and alternate delegates to the secretary of this society no later than 120 days prior to annual meeting.

*Section 10.* Any component society which fails to pay its assessment or make the annual report required on or before March fifteenth shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

A member is in good standing unless otherwise disqualified, whose dues are paid on or before the first day of March of the current year. Immediately after the first of March, each delinquent member shall be notified that in consequence of nonpayment of dues, his membership is delinquent. If dues remain unpaid as of June thirtieth of the current year, membership shall be dropped automatically. The member may be reinstated by paying all delinquent dues, provided, in the interim, he has not been guilty of conduct prejudicial to membership; but if two or more years have elapsed since he was a member in good standing, he must in addition, make application as a new member.

*Section 11.* The Constitution and Bylaws of the Illinois State Medical Society and of the American Medical Association, together with the Principles of Medical Ethics of the American Medical Association, shall be binding upon the members of the component societies.

## CHAPTER XI. DISCIPLINE

### PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Ethical Relations Committee.* Each component society may have, either by appointment or election, an Ethical Relations Committee, whose duty it shall be to prosecute formal charges of unethical conduct. In the event that the county society does not have such a committee, the district Ethical Relations Committee shall function in its behalf.

All parties may have legal counsel present to advise and counsel them during the proceedings, but such counsel may not participate in the proceedings, and may be excluded from the hearing by the chairman or by vote of the committee.

The component society Ethical Relations Committee may establish reasonable rules of procedure, and they shall not be bound by the technical rules of evidence as the same pertain in courts of law. In all proceedings before such Ethical Relations Committees, the complainant, the accused and all witnesses before the committee shall be placed under oath.

The Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 2. *Offenses.* Any member of a component society shall be subject to censure, suspension or expulsion by such component society when

- A. He has been adjudged guilty by proper civil authorities of a criminal offense involving moral turpitude, or
- B. He has been adjudged guilty by his component society in accordance with the procedural requirement of these bylaws:
  1. of a gross misconduct as a physician, or
  2. of a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association.

Section 3. *Charges Initially Presented to the Illinois State Medical Society.* Original complaints received by the Illinois State Medical Society shall be referred directly to the secretary of the component society of which the accused is a member or to the district Ethical Relations Committee.

Section 4. *Principles of Justice.* The following principles of justice shall guide the Ethical Relations Committee in all disciplinary procedures.

- A. An accused is presumed to be innocent until he has been proven guilty.
- B. Formal charges before the Ethical Relations Committee of the component society or district Ethical Relations Committee must be presented under oath by the complaining party.
- C. A trial shall be held by the committee within 30 days after the formal charges have been filed, unless continued by the chairman of the committee upon good cause shown.

D. The individual against whom formal charges have been filed shall be sent a copy of said charges by certified mail at least 10 days before the date set for the trial, together with a statement of the rights of the accused as follows:

1. to be represented by any member of the society as counsel and that he may have legal counsel present;
2. to cross-examine witnesses;
3. to offer in evidence any pertinent records or documents;
4. to object to any testimony or exhibits offered in evidence;
5. to address the trial body in his own behalf;
6. to be tried only on the specific charges filed;
7. to have stricken from the record any improper testimony or exhibits;
8. to appeal to the Board of Trustees of the Illinois State Medical Society.

Section 5. *Records.* A comprehensive stenographic record of the proceedings, together with all exhibits, must be kept for reference, and shall be available until final adjudication has been made.

In the event of an appeal being taken from the verdict of the local or district Ethical Relations Committee, the stenographic record shall be forwarded by certified mail to the Board of Trustees of the ISMS at least ten days prior to the date the appeal is to be heard.

If the component society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the accused not guilty.

Section 6. *Verdict.* The committee, sitting as a trial body, shall find the accused either guilty or not guilty. If the verdict is guilty, the trial body shall recommend censure, suspension or expulsion.

The findings of the trial body must be presented to the component county society for approval or rejection. The accused must be notified by certified mail at least ten days before the date set for the meeting at which this action will be taken. If the findings of the trial body are against the accused the secretary of the component society shall acquaint the accused, by certified mail, with his right of appeal within thirty days to the Board of Trustees of the Illinois State Medical Society.

### PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. *Illinois State Medical Society Ethical Relations Committee.* The Board of Trustees shall appoint from its members, an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the Illinois State Medical Society or its component societies, and charges of misconduct of members of the Society.

Section 2. *Appeals from Component Society Verdicts.* Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. (Appeals must be accompanied by a comprehensive stenographic record of the proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of the

Illinois State Medical Society shall find the accused "not guilty"). The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. *Verdict.* The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. *Notification and right of appeal.* The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

## CHAPTER XII. PEER REVIEW

### PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Peer Review Committee.* Each component Society shall have, either by appointment or election, a Peer Review Committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients, institutions, insurance carriers, or government agencies.

The district peer review committee shall function and operate on behalf of any county society which does not establish such a committee.

Section 2. The committee shall consist of a chairman and such members representing the various specialties, including family practice, as each individual county society shall determine. Such committee should have access to counsel from each of the various medical specialties. The component county society may establish reasonable rules of procedure but shall not be bound by the technical rules of evidence as the same pertains in courts of law. All proper complaints shall be reduced to writing and shall be signed by the individual making the complaint.

Section 3. Original complaints received by the Illinois State Medical Society shall be referred to the proper county society or to the district committee.

Section 4. The Peer Review Committee shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 5. The Peer Review Committee shall initiate consideration of all complaints and matters filed with it within 60 days from the date of filing and shall render an opinion within 30 days after the conclusion of the hearing. In the event the committee does not follow this procedure any party may appeal for relief to the proper district committee whose procedure shall be the same as is set forth herein for county societies.

Section 6. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings

in writing to all parties involved. In the event the investigation and study of the committee results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing to the component society.

Section 7. In its study and deliberations the Peer Review Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 8. Any party to the proceedings considering himself aggrieved by the findings and recommendations of the committee shall have the right to appeal through the component society to the Illinois State Medical Society.

Section 9. In the event of an appeal to the Illinois State Medical Society, the county society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the opinions of the county or district committee. Any appeal hereunder shall be filed with the Illinois State Medical Society within 30 days after the final opinion of the county or district committee has been rendered.

### PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. All appeals received by the Illinois State Medical Society shall be referred to the Council on Economics and Peer Review, which shall review opinions of the county or district peer review committee. The council shall have the power to counsel with and obtain information from medical specialists when appropriate. The Council shall have the power to review both the procedural and substantive aspects of any appeal before it.

Section 2. The council upon receiving notice of an appeal shall set the matter for hearing within 30 days after the appeal has been filed and at such hearing shall review the record sent to it from the county society or district society, receive additional pertinent evidence any interested party desires to offer and render its conclusions and findings in writing, copies of which shall be mailed to all interested parties. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings to all parties involved. The conclusions and findings shall be advisory only.

Section 3. The Council on Economics and Peer Review of the Illinois State Medical Society shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 4. In the event the investigation and study of the Council results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or

Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing back to the component society.

### CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

### CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these

Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

## CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

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# 1974-1975

## Policy Manual of the

### Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

- (1) approve, amend, or reject—
- (2) refer the statement to the Board for reconsideration and subsequent report—
- (3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House may appear as a portion of the annual report of the Policy Committee, or they may be contained in other reports to the House. The final statements for publication in this Policy Manual are to be prepared by the Policy Committee. Any member of the Illinois State Medical Society may submit a policy statement for consideration.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

The Illinois State Medical Society shall support policy statements approved by the House of Delegates of the American Medical Association.

National policy is the prerogative of the national association. Until specific contrary action emanates from the AMA House of Delegates, the Board of Trustees and the officers of the ISMS shall consider all such policy as binding.

Policy action at the state level does not rescind official AMA rulings in Illinois.

The same "chain of command" should exist between the county medical society and the ISMS House of Delegates. Policy established at the State Society level must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

## PROFESSIONAL POLICIES

### Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Performance of abortions should be carried out in accordance with current guidelines as promulgated by the House of Delegates. If not in conflict with state and federal law, an abortion so performed shall not be considered unethical. No physician shall be required to perform or participate in an abortion.

### Alcoholism

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational and/or social adjustments as a direct consequence of persistent and excessive use of alcohol.

Insurance companies are encouraged to include appropriate coverage for alcoholism in health insurance policies similar to coverage for any other illness and general hospitals, both public and private, are encouraged to accept alcoholic patients (both in-patient and out-patient) for detoxification and rehabilitation.

### Alcoholism Education

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that mental health clinics should enlarge their services to include treatment and counseling of alcoholics and their families and, where appropriate, collaborate with Alcoholics Anonymous as well as half-way houses; that education programs aimed at alcohol abusers who are drivers should be encouraged and legal restrictions established to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects should be encouraged.

### Ambulance Services

All ambulance services should meet minimum stand-

ards as developed from time to time by the Illinois State Medical Society and the State of Illinois.

## Athletic Programs

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential.

## Audits & Surveys

### (Hospital, nursing homes, etc.)

Audits and surveys which impinge on personal privacy, patient care and local hospital trustee and medical decisions as to management should not be condoned.

## Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.

## Blood Procurement

Inasmuch as blood procurement affects the entire community, any blood procurement program should be carried out only with the approval of the local county medical society involved.

## Communicable Diseases

Physicians, especially those engaged in public health work, should enlighten the public concerning all regulations and measures for the prevention and control of communicable diseases. When an epidemic prevails, a physician shall continue his labors without regard to his own health.

## Community Health Week

The medical profession shall provide the scientific leadership to focus attention on the health needs of the community and to encourage and assist in developing Community Health Week activities during the winter or spring of the year.

## Comprehensive Health Planning

Upgrading of local health facilities should be implemented through Comprehensive Health Planning on a home rule basis rather than through metropolitan oriented advisory services. Where a county medical society is unable to enter into meaningful participation in areawide health services planning, this function may be assumed by an appropriate ISMS District Committee or, where the appropriate District Committee is unable to act, by the Illinois State Medical Society.

## Confidentiality

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileges must be continued in accomplishment of the treatment of human illness. Section 9 of the Principles

of Medical Ethics states that "A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community." The Illinois State Medical Society re-affirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

## Conflict of Interest

When a case of conflict of interest arises and is self-evident, by the attitude shown by the individual concerned, it should be referred to the Executive Committee of the Board of Trustees of the ISMS for consideration.

## Continuing Education

Continuing education shall be one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should continue to support the multi-faceted approach to continuing medical education as now endorsed by the Illinois Council on Continuing Medical Education.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

In the certification of educational quality of continuing medical education programs, the Illinois State Medical Society should have a primary role. Physicians should be encouraged to participate in self-assessment test programs prior to registering for such hospital courses and other learning activities.

## Cultists, Association with

The Judicial Council of the American Medical Association has ruled that it is unethical to associate VOLUNTARILY with an individual who practices as a member of a "cult."

## Disaster Control

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

## Discrimination—(see "Freedom of Choice")

## Drugs, Prescriptions

Substitution of prescribed drugs by pharmacists is opposed, except in cases of extreme emergency, unless there be full explanation and agreement by both the patient and the doctor.

## Ethics

Cases involving ethics shall reach the state society level only by means of an appeal. As outlined in the Bylaws, the state society committee shall serve only as an appellate body to review such cases.

## **Examinations**

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.

## **Experimental Medical Procedures**

In order to conform to the ethics of the American Medical Association, three requirements must be satisfied in connection with the use of experimental drugs or procedures:

1. The voluntary consent of the person on whom the experiment is to be performed should be obtained.
2. The danger of each experiment must be previously investigated by animal experimentation.
3. The experiment must be performed under proper medical protection and management.

## **Fee Schedules**

No member or committee shall be permitted to approve a fee schedule for the Illinois State Medical Society until it has been submitted to and approved by the House of Delegates or the Board of Trustees. Fees should be commensurate with services rendered.

## **Freedom of Choice**

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

## **Foundations for Medical Care**

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost. Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

## **Health Care—Ancillary Services**

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, problems of migrant workers, etc., and any other area which involves the health of the people of this state.)

## **Health Care Costs**

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

## **Health Careers**

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.

## **Health Screening by Paramedical Personnel**

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.

## **Hospitals**

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

## **Hospital-Medical Staff-Management Relationship**

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

## **Hospital Records and Their Availability**

Hospital records are privileged information and the property of the patient, kept in trust by the hospital. They are not to be released except on a court order.

Upon receipt of a request signed by the patient, an abstract or a summary shall be provided when needed, to insurance companies, governmental agencies, consulting physicians, etc.

## **Hospital Staff Assessments**

The medical staff of a hospital does not have the privilege or the right to make compulsory assessments of members of the medical staff for building funds, or to demand an audit of staff members' personal financial records as a requisite for staff appointments.

## **Immunization Program**

Illinois residents should be provided all types of immunization. Physicians are requested to provide this pro-

tection especially to all children, or to encourage the local public health agency to perform this function.

Every school should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

### **Impartial Medical Testimony**

The ends of justice are served when impartial medical witnesses are available to give testimony. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.

### **Indigent, The Care of the**

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

### **Insurance Plans for Patients**

ISMS endorses the principle of voluntary health insurance. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

### **Laboratories**

All laboratories providing medical data should be under the direct supervision of a physician.

### **Medical Care, Provision of**

Medical care shall be provided regardless of the ability of the patient to pay. Physicians shall not refuse to render needed emergency care to any patient.

### **Medical Education**

The Illinois State Medical Society supports development of innovative curricular and co-curricular programs in medical education maintaining a firm foundation in the basic sciences.

### **Medical Examiners**

ISMS favors a medical examiner system throughout the state in preference to a coroner system, wherever practical.

### **Medical Psychotherapy**

Medical Psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and non-verbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical

psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches, who has had training in psychiatric medicine.

### **Mental Health**

The Illinois State Medical Society strongly opposes the double standard of care in state hospitals and favors elimination of permit physicians (unlicensed physicians practicing in state institutions). Every effort should be made to extend educational opportunities to these permit physicians to enable them to achieve full licensure.

Each constituent county society should cooperate fully with and support local units of the Department of Mental Health in their patient care efforts, specifically seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.
2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.
3. Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.
4. Arrangements for emergency mental health care, i.e., crisis intervention, to be available areawide.

All physician or other health service provided to the Department of Mental Health, other than that by full-time employees, should be on the same fee-for-service basis as any other medical service which is paid by the patient or third party insurer.

A physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

### **Minors, Medical Treatment of**

Where parental consent is not legally required for medical treatment of minors, the physician's judgment shall prevail as to whether or not the parents should be notified of such treatment.

### **Multiphasic Screening**

Automated multiphasic health testing and screening laboratories are recognized as an extension of services available to the physician for the health needs of individual patients. A position statement on multiphasic health testing, developed by the ISMS Council on Environmental and Community Health, and the American Medical Association Guidelines for establishing and operating such programs are attached as an appendix to the Policy Manual.

### **Nurses—Shortage**

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.

### **Nursing Homes**

Every patient receiving long-term nursing care should have an attending physician who acknowledges his con-

tinuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician.

## Nutrition

Prophylactic use of iron fortified foods is approved in accordance with a 7-point statement developed by the Nutrition Committee and the Council on Environmental and Community Health in 1971.

## Occupational Health

Occupational health is an essential ingredient of employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of industrial physicians.

## Osteopaths, Association with

Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois.

## Physician-Patient Relationship

All committees dealing with the review of physician-patient relationship in hospitals and nursing homes are urged not to release findings to any third parties except by subpoena or court order. Any reports issued by the committees involved should be submitted to the chief of staff for his disposition.

## Prepayment Plans and Organizations

It is not within the province of ISMS to act in other than an advisory capacity when working with a "third party plan," and its best efforts should be directed toward supplying guidance, education and communications between the membership and the prepayment plans and organizations involved.

The principle of free enterprise as exemplified by private insurance companies and the "Blue" plans is to be endorsed.

Such plans should recognize that free standing medical and surgical facilities are acceptable methods of delivering high quality health care. Reimbursement for expenses incurred as an outpatient in such facilities should be included in the benefits of these plans.

## Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and co-operating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by the state/federal programs to physicians shall be based upon the usual and customary fee concept.

An extensive program of education should be conducted for the recipients of public aid. This should in-

clude the intelligent handling of all monies provided.

Rehabilitation of all recipients should be of paramount concern.

## Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

Local public health service jurisdictions should be consolidated into sufficiently large geographic and population districts to achieve program efficiency.

## Public Safety

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.

## Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

## Relative Value

The Relative Value Study is not a fee schedule and is to be used for information only. All fee payments should be based on the usual, customary and reasonable concept.

No coefficient shall be established at the state level. The data contained in the study may be used by the ISMS, its committees or by any county medical society.

The study should be revised at appropriate intervals upon recommendation of the Relative Value Committee with approval of the Board of Trustees.

Upon request, copies may be furnished third party purveyors of health care services.

## Smoking

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and will encourage medical staff action to make hospitals tobacco smoke-free.

## Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable. Representatives to serve in this capacity may be nominated

by the specialty society, approved by the Board of Trustees of ISMS, and designated as consultants to the council without vote, in compliance with the Bylaws.

## Veterans Administration

It is our belief that a Veterans Administration hospital should admit only those patients with service-connected disabilities, except in those instances where the veteran is financially unable to pay for his medical care and hospital services, as shown by a means test.

## ADMINISTRATIVE POLICIES

### AMA-ERF

The Illinois State Medical Society's dues billing form shall include the names of all medical schools in Illinois so that every member may designate which school is to receive his AMA-ERF contribution.

### Assessments

Compulsory assessments of members of hospital staffs for any purpose are unethical and improper.

### Autonomy of County Medical Services

In all areas, the county medical society shall be autonomous, except that no ruling by any county medical society shall conflict with the Principles of Medical Ethics of the American Medical Association or with the Constitution and Bylaws of the Illinois State Medical Society.

### Birth Certificates

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other than approved purposes.

### Budgets—(see "Financial Policies")

### Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Elective committees should serve for uniform terms of office—preferably three years. These terms of office should be held on a staggered basis to provide continuity in the committee structure. Individual tenure on any committee should be limited to a maximum of nine years of continuous membership—whether elected or appointed.

Physicians appointed to an Illinois State Medical Society committee must be members in good standing of this Society.

### Constitution and Bylaws

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, mak-

ing sure that the published changes reflect the thinking expressed by the action of the House.

### Co-operation with the American Medical Association

Actions of the AMA House of Delegates are binding upon its membership at all levels, county, state and national.

(Since all members of the Illinois State Medical Society are also members of the American Medical Association, this is universally true in Illinois. The right to disagree, the right to protest, the right to become "the loyal opposition" is not questioned. However, until such time as the AMA House has reversed its decision, it is mandatory that the membership abide by the will of the majority.)

### Dues, Recommendation of the Board to the House

The chairman of the Board of Trustees shall place the question of dues for the coming year on the agenda for consideration by the Board of Trustees in time for the Board to present its recommendations to the House of Delegates each year.

Immediately following this meeting, written notice of the recommendation regarding dues for the next fiscal year, shall be mailed to all delegates and alternate delegates from the component societies, and also to all presidents and secretaries of county medical societies. This recommendation shall also be published in the *Illinois Medical Journal* as a part of the annual report of the Chairman of the Board.

### Education, Primary and Secondary

Primary and secondary education is a community problem. In order to retain jurisdiction of these grade schools, finances should be raised by taxation at the local level.

### Facility Medical Boards (Physicians)

In all legislation which establishes boards for the administration of medical facilities operated by governmental units, at least one-third of the board should be physicians licensed to practice medicine in all its branches.

### Federal Funds

When a federal government assistance program is essential it should be conducted under the administration and control of local government. The Society does not favor any federal assistance program which removes administrative control from the state or local level.

### Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(4) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(5) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(6) In addition to fixed reserves, the development of a contingency reserve is desirable.

(7) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.

## **House of Delegates, Special Meetings of**

When a special meeting of the House of Delegates is scheduled which may involve an increase in dues or a special assessment, the call for that meeting shall contain specific notification of that possibility.

## **Individual Rights**

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with this Society's basic philosophy.

## **Journal Publications**

The Publications (Journal) Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the *Illinois Medical Journal*.

## **Lay Employees' Functions**

Policy is established by the House of Delegates.

Staff shall cooperate with officers and committee chairmen in setting up activities and in carrying out all necessary routine.

Staff also shall keep new officers and committee chairmen aware of policy statements, and assist them in the preparation of reports to the House of Delegates to:

change existing policy

establish new policy

request House approval of committee projects and/or procedure involving policy.

Committees shall be informed of their right to set up operating rules and regulations.

## **Legal Counsel**

The legal counsel of the Illinois State Medical Society shall concern himself with official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Executive Administrator.

## **Legislation**

All matters pertaining to state or federal legislation shall be referred to the Governmental Affairs Council

for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council on Governmental Affairs of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any Council or Committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House Committees in support of, or in opposition to, the legislation recommended by the Council or Committee.

## **Legislative Intrusion into Medical Judgment**

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physicians' judgment as to which procedures are appropriate and in the best interest of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.

## **Mailing List**

The use of the mailing list of ISMS members must be approved by special action of the Board of Trustees.

## **Medical Representation in Government Planning**

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the State Society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

## **Membership in Paramedical and Service Organizations**

Membership in Chambers of Commerce (city, state and national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

## **Membership of Osteopathic Physicians in ISMS**

Osteopathic physicians who meet all qualifications for membership, base their practice on the same scientific principles as those adhered to by members of the AMA,

and are licensed to practice medicine in all its branches in Illinois, may be accepted as active members by the county medical societies throughout the state, and be accorded all privileges of full membership at the county and state levels and be so reported to the American Medical Association for acceptance at that level.

## Placement Service

Before the Physicians' Placement Service recommends that a town in Illinois be listed as needing a physician, it shall be established that the need actually exists; that the community can support a physician; that certain physical assets (office—home—schools, etc.) are available for the physician and his family.

The qualifications of the physician also shall be ascertained prior to furnishing him with the list of available areas in Illinois needing a physician.

## Policy Statements

Policy statements shall be defined as guide lines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.

Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy.

## Polls, Opinion

The vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership. Since delegates are the duly elected representatives of their county medical societies and their voting reflects the thinking of their constituents, a majority opinion has been expressed, and a membership poll becomes unnecessary except under very exceptional conditions.

## Press

All county medical societies should be encouraged to cooperate with the local press. The public should be provided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.)

## Publication of Research Data

In releasing research material for publication in the *Illinois Medical Journal*, or any other media, extreme care should be exercised. The welfare and privacy of the patient, the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the Board of Trustees is suggested. All such inquiries should be addressed to its chairman.

## Public Affairs

No officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name as an officer or a member of the Board to be used in lists endorsing candidates for public office. Naturally his right to this privilege as a private individual is not affected.

## Rebates

In conformity with the AMA Principles of Ethics, rebates of any nature to any member, county or regional medical society, are unethical. This statement on rebates was developed as a result of a letter regarding collection services. It read in part:

"It is our policy to remit to a participating association the sum of 10 per cent of the gross book sales to its members in addition to 10 per cent of the gross commissions received from collections. A report and accompanying payment is submitted monthly from our office."

## Reference Committee Appointments

Whenever possible at least two members shall be retained on all reference committees for the following year in order to effect continuity of experience.

## Reference Service

Physician reference service shall be the responsibility of the county medical society. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.

## Stationery, Use of Official

No officer, trustee, committee chairman or staff director is to use the official stationery of the Illinois State Medical Society for personal statements of any nature. This shall pertain especially to the endorsement of any candidate for public office.

## Surveys

The Illinois State Medical Society endorses the principle of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval.

## Uniform Health Insurance Claim Form

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians.

## Woman's Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

## **APPENDIX**

### **Multiphasic Health Testing Council on Environmental and Community Health Statement**

During the recent past there has been an upwelling of various automated or multiphasic health testing or screening programs. The use of the results of such testing has at times led to a false sense of security on the part of patients, whereas other programs are being foisted on the public with the view to making money with very little concern for an individual's well being. Other programs are offered as having direct, immediate and practical medical value, without review by a physician. These many concerns prompt the necessity of a position statement on the use and application of such programs.

There is a place for computer and automated multiphasic testing and screening programs as an extension of the services available to the physician as he considers each individual case. It is entirely possible that such a mechanism will enable a physician to expand his scope of operation.

Forms of automated multiphasic health testing have been used by public health agencies and centers for developmental research in epidemiology. In these programs, asymptomatic control patients have been tested. Testings have been done to establish medical priorities or case findings in communities. Other testing has been done to separate those who probably have certain characteristics from those who do not.

Occupational or industrial health programs have used testing programs for the betterment of employees' health and working conditions. Programs such as these, whether a pre-employment examination or a study to control health hazards, are not necessarily related to medical care as such. The physician in charge may or may not at the same time be the attending physician of the employee.

As far as automated multiphasic health testing programs for individuals are concerned, these programs obtain health-related data and act as data collecting sources, following a routine using technicians or mechanical and electronic devices to determine facts. In several hours a variety of tests and measurements can be made which may provide a profile of an individual's physical status. Such a profile can be of value to a physician. The testing is not diagnosis or interpretation.

Some individually oriented automated multiphasic health testing programs are operated commercially on a for-profit basis. Many of these do determine and report facts accurately. Some, however, give the appearance of encouraging individuals to be tested without a medical referral for the tests. Some indicate that when the results are compared against standards or norms the individual does not even have to see a physician. Some, in addition, perform a battery of tests which are not requested by an attending physician.

The physician's ethical responsibility is to provide his patient with high quality services. He should not utilize services of any testing program unless he has the utmost confidence in the quality of its services. He must assume professional responsibility for the best interest of the patient. As a professional man, the physician is entitled to compensation for his services. However, he should not be engaged in the commercial conduct of a testing or screening program and should not make a mark up commission or profit on services rendered by others. It is not, in itself, unethical for a physician to own an automated multiphasic facility or interest. The use the physician makes of this ownership may be unethical.

An attending physician may not receive a rebate, referral fee, or commission from a program whose facilities have been used by his patients.

An automated health testing facility is a fact finding and reporting system. It must be limited to fact finding and exclude interpretation. Findings disclosed must be interpreted only by physicians.

Offering a combination or medical and non-medical service to the public is to be avoided. The public may be confused as to what constitutes reporting a fact and what constitutes the making of a medical diagnosis.

A practicing physician may recommend multiphasic health testing where he believes it may be helpful to him in the care of his patient. Prudence dictates that the physician be selective in recommending or requiring patients to utilize the services of an automatic health testing facility and not adopt the practice of routinely requiring that all patients, or all new patients, undergo such testing. When good medical judgment suggests the

desirability of such testing, the physician should explain in general the nature and purpose of the testing. The patient must be afforded freedom to choose between automated multiphasic health testing facilities, if available. Alternatives in the way of single tests should be offered patients, where possible and practical.

An individual who is tested, or a facility which conducts these tests, may neither demand that a physician accept an individual as a patient nor evaluate the tests for the individual. The physician remains free to choose whom he will serve.

A physician employed by an automated multiphasic health testing facility, in conformity with well established policies, should not dispose of his professional attainments to any corporation or to a lay body under terms or conditions which permit the sale of the services of that physician by an agency for fee, nor allow his name or the prestige of his professional status as a physician to be used in the promotion of a commercial enterprise. He should neither aid nor abet an unlicensed individual or corporation to practice medicine.

There is a responsibility for the medical society to educate the public regarding indications for and against multiphasic health testing, to educate the membership of the society regarding ethical responsibilities in these

matters, and the society must be ready to assist persons or corporations that seek advice in setting up multiphasic health testing facilities.

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There is a responsibility for the medical society to educate the public regarding indications for and against multiphasic health testing, to educate the membership of the society regarding ethical responsibilities in these matters, and the society must be ready to assist persons or corporations that seek advice in setting up multiphasic health testing facilities.

## **AMA Guidelines for Establishing and Operating Multiphasic Health Testing Programs**

The following guidelines are recommended for use by physicians and medical societies in providing technical advice and assistance in the planning, development, implementation, and operation of multiphasic health testing programs:

1. Multiphasic health testing is a method of acquiring, storing, collating, and reproducing medical data on individual patients. The testing procedures are considered to be incomplete health services. Provisions must be made for a physician to interpret and evaluate this medical data base as an aid in continuing patient care.
2. The multiphasic testing program should meet applicable licensing requirements and be appropriately evaluated for quality control.
3. Physicians should be involved in the planning and development of testing programs, and the operation of all programs should be supervised by qualified physicians.
4. The system should be designed to make maximum use of allied health professionals and should utilize technical and automated techniques where justified.
5. For professional value and economic feasibility, the program should include tests that are simple, safe, easy to interpret, inexpensive and quick to perform, and that have acceptable sensitivity, specificity, high predictive value, and patient acceptance.
6. The testing system should include the following criteria: reliability, accuracy of output, saving of time of physicians and allied health personnel, adequate utilization, and sufficient flexibility for customization to physician and patient needs. The program should establish individual ethnic, geographic, and other variations of normal and abnormal patterns.
7. The program should provide for confidentiality of patient data.
8. The testing program should be used, where feasible, to meet otherwise unmet community health needs and should be integrated into the continuing health care system.
9. The testing program should be designed to meet various objectives such as diagnostic services, health maintenance, and guidance in management of ongoing illness including chronic disease.
10. Evaluation methodology should be built into the program to determine the acceptance and use, yield, false positives and false negatives, as well as the long-term effects of the program on illness and the need and demand for health services. The program should include a documented accounting system, at least for internal use, and a reasonable cost finding system that would allow for cost analysis and cost summaries.
11. The program should maintain freedom of choice for both the physician and the patient.

# ISMS House of Delegates

## OFFICIAL MEMBERS OF THE HOUSE WITH THE RIGHT TO VOTE

### Officers of ISMS

|   |  |
|---|--|
| President—Fredric D. Lake                   |  |
| 1041 Michigan Ave., Evanston 60202          |  |
| President-elect—J. M. Ingalls               |  |
| 502 Shaw Ave., Paris 61944                  |  |
| Secretary-Treasurer—Jacob E. Reisch         |  |
| 1129 S. 2nd St., Springfield 62704          |  |
| First Vice President—Harold A. Sofield      |  |
| 715 Lake St., Oak Park 60301                |  |
| Second Vice President—Robert R. Hartman     |  |
| 1515A Walnut St., Jacksonville 62650        |  |
| Speaker of the House—Andrew J. Brislen      |  |
| 6060 S. Drexel Blvd., Chicago 60637         |  |
| Vice Speaker of the House—James A. McDonald |  |
| 13 S. 2nd St., Geneva 60134                 |  |

### Board of Trustees

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| Chairman, Board of Trustees—Joseph L. Bordenave   |      |
| 1665 South St., Geneva 60134                      |      |
| 1st District—Joseph L. Bordenave                  | 1977 |
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| 712 N. Bloomington, Streator 61364                |      |
| 3rd District—David S. Fox                         | 1976 |
| 20829 Green Center Court,<br>Olympia Fields 60461 |      |
| Robert T. Fox                                     | 1976 |
| 2136 Robin Crest Lane, Glenview 60025             |      |
| Eugene T. Hoban                                   | 1975 |
| 6429 North Ave., Oak Park 60302                   |      |
| Joseph Skom                                       | 1975 |
| 707 Fairbanks, Chicago 60611                      |      |

## EX-OFFICIO MEMBERS OF THE HOUSE WITHOUT THE RIGHT TO VOTE

### Past Presidents

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|--------------------------|-----------|
| J. Ernest Breed          | 1971      |
| Everett P. Coleman       | 1945-1946 |
| Edward W. Cannady        | 1970      |
| Newton DuPuy             | 1968      |
| Harlan English           | 1964      |
| Edwin S. Hamilton        | 1962      |
| H. Close Hesseltine      | 1961      |
| Charles J. Jannings, III | 1972      |
| Frank J. Jirka, Jr.      | 1973      |
| Willis I. Lewis          | 1954      |
| George F. Lull           | 1963      |
| Burtis E. Montgomery     | 1966      |
| Edward A. Piszczek       | 1965      |
| Caesar Portes            | 1967      |
| Willard C. Scrivner      | 1974      |
| Leo P. A. Sweeney        | 1953      |
| Philip G. Thomsen        | 1969      |
| Arkell M. Vaughn         | 1955      |

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| Chicago, Trustee of the 3rd District  |  |
| Walter C. Bornemeier                  |  |
| Chicago, Trustee of the 3rd District  |  |
| Carl E. Clark                         |  |
| Sycamore, Trustee of the 1st District |  |
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| Sparta, Trustee of the 10th District  |  |

|   |      |
|---|------|
| William M. Lees                         | 1977 |
| 6518 N. Nokomis, Lincolnwood 60646      |      |
| George C. Shropshire                    | 1977 |
| 1525 E. 53rd, Chicago 60615             |      |
| Philip G. Thomsen                       | 1977 |
| 13826 Lincoln, Dolton 60419             |      |
| Frederick E. Weiss                      | 1976 |
| 15643 Lincoln, Harvey 60426             |      |
| Warren W. Young                         | 1975 |
| 3450 Haweswood Dr., Crete 60417         |      |
| 4th District—Fred Z. White              | 1976 |
| 723 N. 2nd St., Chillicothe 61523       |      |
| 5th District—A. Edward Livingston       | 1976 |
| 219 N. Main, Bloomington 61701          |      |
| 6th District—Mather Pfeiffenberger      | 1975 |
| State & Wall Streets, Alton 62002       |      |
| 7th District—Arthur F. Goodyear         | 1976 |
| 142 E. Prairie Ave., Decatur 62523      |      |
| 8th District—Eugene P. Johnson          | 1976 |
| P.O. Box 68, Casey, 62420               |      |
| 9th District—Warren D. Tuttle           | 1975 |
| 203 N. Vine, Harrisburg 62946           |      |
| 10th District—Herbert Dexheimer         | 1975 |
| 301 S. Illinois, Belleville 62220       |      |
| 11th District—Ross Hutchison            | 1977 |
| 126 E. Ninth St., Gibson City 60936     |      |
| Trustee at Large—Willard C. Scrivner    | 1975 |
| Suite 2, 6600 W. Main, Belleville 62223 |      |

### Representatives of County Societies

A complete listing of delegates and alternates to the ISMS House will appear with the convention program.

### George E. Griffin

Princeton, Trustee of the 2nd District

### Lee N. Hamm

Lincoln, Trustee of the 5th District

### George A. Hellmuth

Chicago, Trustee of the 3rd District

### Bernard Klein

Joliet, Trustee of the 11th District

### Ted LeBoy

Chicago, Trustee of the 3rd District

### Warner H. Newcomb

Jacksonville, Trustee of the 6th District

### Joseph R. O'Donnell

Glen Ellyn, Trustee of the 11th District

### Ralph N. Redmond

Sterling, Trustee from the 2nd District

### Paul P. Youngberg

Moline, Trustee of the 4th District

### Darrell H. Trumpe

Springfield, Trustee of the 5th District

### William H. Schowengerdt

Champaign, Trustee of the 8th District

### Charles K. Wells

Mt. Vernon, Trustee of the 9th District

### Past Speakers

Walter C. Bornemeier, Chicago ..... 1961-1964

Edward W. Cannady, Belleville ..... 1964-1967

Maurice M. Hoeltgen, Chicago ..... 1967-1970

Paul W. Sunderland, Gibson City ..... 1970-1973

# AMA DELEGATION

## Delegates to the American Medical Association

To Serve From Jan. 1, 1973 to Dec. 31, 1974  
(elected March 10, 1972)

Carl E. Clark  
225 Edward St., Sycamore 60178  
H. Close Hesseltine  
5807 South Dorchester, Chicago 60637  
Maurice M. Hoeltgen  
4700 W. 95th St., Oak Lawn 60453  
William M. Lees  
6518 North Nokomis, Lincolnwood 60646  
Theodore R. Van Dellen  
435 North Michigan Ave., Chicago 60611  
Charles K. Wells  
117 North 10th St., Mt. Vernon 62864

To Serve From Jan. 1, 1974 to Dec. 31, 1975  
(elected March 28, 1973)

Jack Gibbs  
175 South Main St., Canton 61520  
Theodore Grevas  
1800 Third Ave., Rock Island 61201  
Frank J. Jirka, Jr.  
1507 Keystone Ave., River Forest 60305  
Morgan M. Meyer  
573 South Lombard, Lombard 60148  
Edward A. Piszczeck  
6410 North Leona, Chicago 60646  
Philip G. Thomsen  
13826 Lincoln, Dolton 60419

To Serve From Jan. 1, 1975, to Dec. 31, 1976  
(elected April 6, 1974)

Carl E. Clark  
225 Edward St., Sycamore 60178  
Alfred J. Faber  
2110 Swainwood Dr., Glenview 60025  
H. Close Hesseltine  
5807 S. Dorchester, Chicago 60637  
Maurice M. Hoeltgen  
4700 W. 95th St., Oak Lawn 60453  
William M. Lees  
6518 N. Nokomis, Lincolnwood 60646  
Charles K. Wells  
117 N. 10th St., Mt. Vernon 62864

## Honorary Delegates

Walter C. Bornemeier  
19273 Harleigh Dr., Sartago, Calif. 95070  
Edwin S. Hamilton  
985 Cobb Street, Kankakee 60901  
George F. Lull  
2440 Lakeview Avenue, Chicago 60614  
Burtis E. Montgomery  
37 South Main Street, Harrisburg 62946

## Alternate Delegates to the American Medical Association

To Serve From Jan. 1, 1973 to Dec. 31, 1974  
(elected March 10, 1972)

Alfred J. Faber  
2110 Swainwood Dr., Glenview 60025  
Frank J. Jirka, Jr.  
1507 Keystone Ave., River Forest 60305  
Fredric D. Lake<sup>2</sup>  
2520 North Lakeview, Chicago 60614  
Eugene T. Leonard  
1215 North Alpine, Rockford 61107  
John Ring  
511 East Hawley St., Mundelein 60060  
Fred A. Tworoger  
4753 Broadway, Chicago 60640

To Serve From Jan. 1, 1974 to Dec. 31, 1975  
(elected March 28, 1973)

Herschel Browns  
4600 North Ravenswood Ave., Chicago 60640  
Allison L. Burdick, Jr.  
10 West Ontario, Oak Park 60302  
Jerry M. Ingalls  
Medical Center, Paris 61944  
Joseph R. O'Donnell  
444 Park Ave., Glen Ellyn 60137

George Shropshire  
1525 East 53rd St., Chicago 60615  
Paul W. Sunderland  
214 North Sangamon, Gibson City 60936  
Glen Tomlinson  
1825 West Harrison St., Chicago 60612

To Serve From Jan. 1, 1975, to Dec. 31, 1976  
(elected April 6, 1974)

Fredric D. Lake  
2520 N. Lakeview, Chicago 60614  
Eugene T. Leonard  
1215 N. Alpine, Rockford 61107  
John Ring  
511 E. Hawley St., Mundelein 60060  
Fred A. Tworoger  
4753 Broadway, Chicago 60640  
Theodore R. Van Dellen  
435 N. Michigan Ave., Chicago 60611

<sup>1</sup>Elected to Delegate position March 28, 1973, effective Jan. 1, 1974

<sup>2</sup>Elected to fill unexpired term of Frank J. Jirka, Jr.

# Officers of County Medical Societies

## 1974

| COUNTY  | PRESIDENT   | SECRETARY  |
|---|---|--|
| ADAMS<br>Members: 86-Dist. No. 6  | George H. Eversman<br>1415 Vermont, Quincy 62301        | Julio del Castillo<br>Ill. St. Bank Bldg., Quincy 62301  |
| ALEXANDER<br>Members: 6-Dist. No. 10  | Gemo Wong<br>2020 Cedar St., Cairo 62914                | Charles L. Yarbrough<br>800 Commercial, Cairo 62914      |
| BOND<br>Members: 8-Dist. No. 7  | James R. Goggin<br>207 N. 2nd St., Greenville 62246     | M. Kenneth Kaufmann<br>105 E. College, Greenville 62246  |
| BOONE<br>Members: 14-Dist. No. 1  | M. Joseph Carlisle<br>115 W. Lincoln, Belvidere 61108   | Earl S. Davis<br>119 S. State, Belvidere 61108           |
| BUREAU<br>Members: 22-Dist. No. 2   | Kent Monroe<br>207 E. St. Paul, Spring Valley 61362     |  |
| CARROLL<br>Members: 9-Dist. No. 1   | C. G. Piper<br>203 W. Market, Mt. Carroll 61053         | Eliseo M. Colli<br>102 E. Washington, Mt. Carroll 61053  |
| CASS-BROWN<br>Members: 6-Dist. No. 6  | R. A. Spencer<br>115 W. 4th St., Beardstown 62618       | B. A. DeSulis<br>115 W. 4th St., Beardstown 62618        |
| CHAMPAIGN<br>Members: 209-Dist. No. 8<br>Larry Booth, Exec. Sec.<br>407 S. 4th St.<br>Champaign 61820       | Stanley Smith<br>Carle Clinic, Urbana 61801             | H. Ewing Wachter<br>1609 W. Springfield, Champaign 61820 |
| CHRISTIAN<br>Members: 19-Dist. No. 7  | R. B. Siegert<br>217 S. Locust, Pana 62557              | J. W. Murphy<br>301 S. Webster, Taylorville 62568        |
| CLARK<br>Members: 6-Dist. No. 8   | Howard G. Johnson<br>Casey Medical Center, Casey 62420  | James R. Buechler<br>P.O. Box 219, Marshall 62441        |
| CLAY<br>Members: 6-Dist. No. 7  | A. Paul Naney<br>Flora Clinic, Flora 62839              | Donald L. Bunnell<br>Flora Clinic, Flora 62839           |
| CLINTON<br>Members: 14-Dist. No. 7  | M. B. Floreza<br>118 N. Oak, Trenton 62293              | F. H. Ketterer<br>289 N. Main, Breese 62230              |
| COLES-CUMBERLAND<br>Members: 37-Dist. No. 8   | Guy Harper<br>904 Third, Charleston 61920               | J. D. Heath<br>6 Orchard Dr., Charleston 61920           |
| CRAWFORD<br>Members: 13-Dist. No. 8   | M. D. Miodus<br>Oblong Clinic, Oblong 62449             | W. B. Schmidt<br>408 S. Cross, Robinson 62454            |
| DE KALB<br>Members: 55-Dist. No. 1  | H. Logan Fisher<br>1838 Sycamore Rd., De Kalb 60115     | William Deschler<br>225 Edwards, Sycamore 60178          |
| DE WITT<br>Members: 10-Dist. No. 5  | John W. Veirs<br>219 E. Main, Clinton 61727             | Charles A. Ramey<br>215 E. Main, Clinton 61727           |
| DOUGLAS<br>Members: 9-Dist. No. 8   | Humberto Mondul<br>100 W. Sale, Tuscola 61953           | Elmer S. Allen<br>120 S. Locust, Arcola 61910            |
| DU PAGE<br>Members: 468-Dist. No. 11<br>Lillian Widmer, Exec. Sec.<br>646 Roosevelt Rd.<br>Glen Ellyn 60137 | Robert D. Dooley<br>5101 Willow Springs, LaGrange 60525 | James P. Campbell<br>322 N. Blanchard, Wheaton 60187     |
| EDGAR<br>Members: 16-Dist. No. 8  | Charles Salesman<br>Box 426, Paris 61944                | J. M. Ingalls<br>502 Shaw Ave., Paris 61944              |
| EDWARDS<br>Members: 2-Dist. No. 9   | Paul S. Neirenberg<br>7 W. Main, Albion 62806           | Andrew Krajec<br>Box 336, West Salem 62476               |
| EFFINGHAM<br>Members: 20-Dist. No. 7  | H. E. Morales<br>300 N. Maple, Effingham 62401          | L. Beis<br>702 W. Kentucky, Effingham 62401              |

| COUNTY   | PRESIDENT  | SECRETARY   |
|--|--|---|
| FAYETTE<br>Members: 10-Dist. No. 7   | D. H. Rames<br>1029 N. 8th, Vandalia 62471                 | E. A. Kuehn<br>501 W. Gallatin, Vandalia 62471              |
| FORD<br>Members: 8-Dist. No. 11  | William A. Garrett<br>Sibley 61773                         | Paul W. Sunderland<br>214 N. Sangamon, Gibson City 60936    |
| FRANKLIN<br>Members: 22-Dist. No. 9  | Loren L. Love<br>6 Hillcrest Dr., Christopher 62822        | D. P. Richerson<br>P.O. Box 99, Christopher 62822           |
| FULTON<br>Members: 29-Dist. No. 4  | Robert W. Ridley<br>Coleman Clinic, Canton 61520           | Marvin E. Schmidt<br>210 W. Walnut, Canton 61520            |
| GALLATIN<br>Members: 1-Dist. No. 6   |  | John E. Doyle<br>Ridgway 62979                              |
| GREENE<br>Members: 6-Dist. No. 6   | Gary L. Turpin<br>712 S. College, Greenfield 62044         | James C. Reid<br>Fillager Mem. Clinic, Greenfield 62044     |
| HANCOCK<br>Members: 9-Dist. No. 4  | Werner Schoenherr<br>Bowen 62316                           | James E. Coeur<br>630 Locust, Carthage 62321                |
| HENDERSON<br>Members: 1-Dist. No. 4  |  | Silvino Lindo, Jr.<br>Biggsville 61448                      |
| HENRY-STARK<br>Members: 31-Dist. No. 4   | Luis J. Garcia<br>719 Elliott, Kewanee 61443               | David E. Stearns<br>513 Elliott, Kewanee 61443              |
| IROQUOIS<br>Members: 18 Dist. No. 11   | S. D. Roeder<br>845 S. 4th St., Watseka 60970              | Dale Learned<br>219 N. Central, Gilman 60938                |
| JACKSON<br>Members: 63-Dist. No. 10  | Allan Bennett<br>P.O. Box 2347, Carbondale 62901           | Paul Lorenz<br>P.O. Box 2347, Carbondale 62901              |
| JASPER<br>Members: 2-Dist. No. 8   | Don L. Hartrich<br>1211 W. Jourdan, Newton 62448           | Monico Low<br>309 S. Van Buren, Newton 62448                |
| JEFFERSON-HAMILTON<br>Members: 36-Dist. No. 9  | Kelly M. Berkley<br>Doctors Pk. Rd., Mt. Vernon 62864      | Antonio Boba<br>P.O. Box 643, Mt. Vernon 62864              |
| JERSEY-CALHOUN<br>Members: 11-Dist. No. 6  | Bernard Baahnan<br>Medical Center, Hardin 62047            | Clyde Wieland<br>Maple Summit Rd., Jerseyville 62052        |
| JO DAVIESS<br>Members: 8-Dist. No. 1   | Wilbur E. Johnson<br>Galena 61036                          | Lyle A. Rachuy<br>323 N. Main, Stockton 61085               |
| KANE<br>Members: 274-Dist. No. 1<br>Michael Wild, Exec. Dir.<br>214 W. State St.<br>Geneva 60134                   | James E. Habegger<br>32 S. Lincoln, Geneva 60134           | James C. Pritchard<br>1725 S. St., Geneva 60134             |
| KANKAKEE<br>Members: 91-Dist. No. 11   | Preston W. Sawyer<br>70 Meadowview Ct., Kankakee 60901     | A. A. Palow<br>555 S. Schuyler, Kankakee 60901              |
| KENDALL<br>Members: 7-Dist. No. 11   | Victor Smith<br>Newark 60541                               | John P. Cullinan<br>Oswego 60543                            |
| KNOX<br>Members: 63-Dist. No. 4  | Kent Kleinkauf<br>632 Bondi Bldg., Galesburg 61401         | Juan Espejo<br>695 N. Kellogg, Galesburg 61401              |
| LAKE<br>Members: 280-Dist. No. 1<br>Julia Schulz, Exec. Sec.<br>P.O. Box 148<br>Gurnee 60031                       | Lionel W. Ganshirt<br>1140 Ash Lawn Dr., Lake Forest 60045 | George A. Olander<br>1950 Sheridan Rd., Highland Park 60035 |
| LA SALLE<br>Members: 97-Dist. No. 2  | Robert Lewis<br>628 Columbus, Ottawa 61350                 | Allan L. Goslin<br>712 N. Bloomington, Streator 61364       |
| LAWRENCE<br>Members: 10-Dist. No. 8<br>Ruth Gariepy, Exec. Sec.<br>Lawrence City Mem. Hosp.<br>Lawrenceville 62439 | R. T. Kirkwood<br>Kensler Bldg., Lawrenceville 62439       | Larry D. Herron<br>N. Main St., Bridgeport 62417            |

| COUNTY  | PRESIDENT   | SECRETARY  |
|---|---|--|
| LEE<br>Members: 20-Dist. No. 2  | Howard Edwards<br>144 N. Court, Dixon 61021               | William McNichols<br>101 W. 1st St., Dixon 61021         |
| LIVINGSTON<br>Members: 29-Dist. No. 2   | Thomas Minoque<br>Fairbury Med. Assoc., Fairbury 61739    | Karl T. Deterding<br>612 E. Water St., Pontiac 61764     |
| LOGAN<br>Members: 20-Dist. No. 5  | H. R. Rivero<br>914 E. Broadway, Lincoln 62656            | Toby E. Silverstein<br>311 8th St., Lincoln 62656        |
| MACON<br>Members: 143-Dist. No. 7<br>Mary J. Bretz, Exec. Sec.<br>1800 E. Lake Shore Dr.<br>Decatur 62521           | A. J. Kiessel<br>1800 E. Lake Shore, Decatur 62521        | William C. Simon<br>1807 N. Edward St., Decatur 62521    |
| MACOUPIN<br>Members: 20-Dist. No. 6   | Robert England<br>403 E. First, Carlinville 62626         | Lee Johnson<br>703 N. Easton, Staunton 62088             |
| MADISON<br>Members: 142-Dist. No. 6   | Alan Skirball<br>2044 Madison, Granite City 62040         | Norman E. Taylor<br>95 S. 9th St., E. Alton 62024        |
| MARION<br>Members: 39-Dist. No. 7   | Samuel S. Rosenblum<br>310 E. Noleman, Centralia 62801    | Walter P. Plassman<br>Box 552, Centralia 62801           |
| MASON<br>Members: 5-Dist. No. 5   | Dario Landazuri<br>125 N. Orange, Havana 62644            | Henry W. Maxfield<br>Mason City 62664                    |
| MASSAC<br>Members: 3-Dist. No. 9  | James L. Bremer<br>805 Market, Metropolis 62960           | Ralph K. Frazier<br>Hospital Dr., Metropolis 62960       |
| MCDONOUGH<br>Members: 27-Dist. No. 4  | Joseph L. Symmonds<br>301 E. Jefferson, Macomb 61455      | Stephen L. Roth<br>Box 258, Colchester 62326             |
| MCHENRY<br>Members: 67-Dist. No. 1<br>Evelyn Rosulek, Exec. Sec.<br>308 E. Kimball<br>Woodstock 60098               | Vincenzo B. Petralia<br>445 Park, Cary 60013              | Aniceto M. D'Sousa<br>1110 N. Green, McHenry 60050       |
| MCLEAN<br>Members: 92-Dist. No. 5<br>Cathy Sengpiel, Exec. Sec.<br>401 W. Virginia<br>Normal 61761                  | Robert G. Killough<br>401 W. Virginia, Normal 61761       | Douglas R. Bey<br>401 W. Virginia, Normal 61761          |
| MENARD<br>Members: 1-Dist. No. 5  | Robert J. Schafer<br>116 N. 5th, Petersburg 62675         | Robert J. Schafer<br>116 N. 5th St., Petersburg 62675    |
| MERCER<br>Members: 4-Dist. No. 4  | R. N. Svendsen<br>209 S. College, Aledo 61931             | Monty P. McClellan<br>309 NW 2nd St., Aledo 61231        |
| MONROE<br>Members: 9-Dist. No. 10   | I. Kremer<br>Columbia 62236                               | Edelberto Maglasang<br>109 W. Legion St., Columbia 62236 |
| MONTGOMERY<br>Members: 15-Dist. No. 5   | L. George Allen<br>400 N. Monroe, Litchfield 62056        | James T. Foster<br>8 Arrowhead Rd., Litchfield 62056     |
| MORGAN-SCOTT<br>Members: 39-Dist. No. 6   | A. M. Paisley<br>209 W. State, Jacksonville 62650         | R. H. Kooiker<br>1600 W. Walnut, Jacksonville 62650      |
| MOULTRIE<br>Members: 5-Dist. No. 7  | Phillip Best<br>14 N. Washington, Sullivan 61951          | Dean McLaughlin<br>112 E. Harrison, Sullivan 61951       |
| OGLE<br>Members: 15-Dist. No. 1   | L. T. Koritz<br>324 Lincoln, Rochelle 61068               | Russell Zack<br>915 Caron Rd., Rochelle 61068            |
| PEORIA<br>Members: 264-Dist. No. 4<br>David W. Meister, Jr.<br>Exec. Sec.<br>427 1st Nat. Bk. Bldg.<br>Peoria 61602 | Willard M. Easton<br>427 1st Nat. Bk. Bldg., Peoria 61602 | Gene O. Hoerr<br>427 1st Nat. Bk. Bldg., Peoria 61602    |

| COUNTY   | PRESIDENT  | SECRETARY  |
|--|--|--|
| PERRY<br>Members: 16-Dist. No. 10  | W. M. Thornburg<br>Medical Group Bldg., DuQuoin 62832        | Bill R. Fulk<br>207 E. Main, DuQuoin 62832               |
| PIATT<br>Members: 6-Dist. No. 7  | George Green<br>121 N. State St., Monticello 61586           | Joseph Allman<br>121 N. State St., Monticello 61856      |
| PIKE<br>Members: 9-Dist. No. 6   | Warren C. Barrow<br>321 W. Washington, Pittsfield 62363      | B. J. Rodriguez<br>868 Mortimer, Barry 62312             |
| PULASKI<br>Members: 1-Dist. No. 10   | A. L. Robinson<br>Box 277, Mounds 62964                      | C. S. Schlageter<br>818 E. Broadway, Sparta 62286        |
| RANDOLPH<br>Members: 19-Dist. No. 10   | L. C. Fiene<br>W. Belmont St., Sparta 62286                  | David R. Benson<br>1200 N. East St., Olney 62450         |
| RICHLAND<br>Members: 23-Dist. No. 8  | Willard J. Eyer<br>119 Market St., Olney 62450               | J. P. Johnston<br>1630 5th Ave., Moline 61265            |
| ROCK ISLAND<br>Members: 164-Dist. No. 4<br>James Koch, Exec. Sec.<br>612 Kahl Bldg.<br>Davenport, Iowa 52801         | N. T. Braatelein<br>635 10th Ave., Moline 61265              | Clarence J. Oerter<br>1915 W. Main, Belleville 62221     |
| ST. CLAIR<br>Members: 209-Dist. No. 10<br>Ed Belz, Exec Sec.<br>4825 W. Main St.<br>Belleville 62223                 | Theodore L. Bryan<br>3120 State St., E. St. Louis 62205      | Gary D. Cody<br>1201 Pine St., Eldorado 62930            |
| SALINE-POPE-HARDIN<br>Members: 26-Dist. No. 9  | Donald H. Yurdin<br>1000 S. 6th St., Springfield 62702       | Warren R. Dammers<br>P.O. Box 281, Harrisburg 62946      |
| SANGAMON<br>Members: 252-Dist. No. 5<br>L. R. Brosi, Exec. Sec.<br>2100 Lindsay Rd.<br>Springfield 62704             | R. R. Dohner<br>103 W. Washington, Rushville 62681           | Robert L. Prentice<br>701 N. Walnut, Springfield 62702   |
| SCHUYLER<br>Members: 3-Dist. No. 4   | Duncan Biddlecombe<br>805 N.W. Sixth, Shelbyville 62565      | Henry C. Zingher<br>West Side Square, Rushville 62681    |
| SHELBY<br>Members: 6-Dist. No. 7   | Erich Awender<br>1717 W. Church, Freeport 61032              | Otto G. Kauder<br>P.O. 395, Shelbyville 62565            |
| STEPHENSON<br>Members: 47-Dist. No. 1  | Theofan R. Trifonoff<br>427 1st Nat. Bk. Bldg., Peoria 61602 | Roger Jenkins<br>1262 W. Stephenson, Freeport 61032      |
| TAZEWELL<br>Members: 45-Dist. No. 5<br>David W. Meister, Jr.<br>Exec. Sec.<br>427 1st Nat. Bk. Bldg.<br>Peoria 61602 | Robert L. Rader<br>200 N. Main St., Anna 62906               | Robert M. Wright<br>427 1st Nat. Bk. Bldg., Peoria 61602 |
| UNION<br>Members: 6-Dist. No. 10   | Grover L. Seitzinger<br>812 N. Logan, Danville 61832         | William H. Whiting<br>Box 410, Anna 62906                |
| VERMILION<br>Members: 86-Dist. No. 8   | Roger Fuller<br>1132 Chestnut, Mt. Carmel 62863              | L. W. Tanner<br>7 N. Virginia, Danville 61832            |
| WABASH<br>Members: 7-Dist. No. 9   | W. Roller<br>309 S. Main, Monmouth 61462                     | C. L. Johns<br>114 W. 5th St., Mt. Carmel 62863          |
| WARREN<br>Members: 10-Dist. No. 4  | Charles Longwell<br>111 S. Washington, Nashville 62263       | Glenn W. Chamberlin<br>219 E. Euclid, Monmouth 61462     |
| WASHINGTON<br>Members: 2-Dist. No. 10  | Edward S. Talaga<br>101 E. Center St., Fairfield 62837       | Jerry L. Beguelin<br>Box 197, Irvington 62848            |
| WAYNE<br>Members: 7-Dist. No. 9  |  | Arthur Marks<br>101 E. Center St., Fairfield 62837       |

| COUNTY  | PRESIDENT  | SECRETARY   |
|---|--|---|
| WHITE<br>Members: 8-Dist. No. 9   | William Courtnage<br>West Main St., Carmi 62821          | Morris McCall<br>So. Plum St., Carmi 62821            |
| WHITESIDE<br>Members: 37-Dist. No. 2  | Howard R. Christofersen<br>101 E. Miller, Sterling 61081 | James McGee<br>1716 Locust, Sterling 61081            |
| WILL-GRUNDY<br>Members: 195-Dist. No. 11<br>Pat Love, Manager<br>58 N. Chicago, Rm. 201<br>Joliet 60431         | Thomas J. Fitzpatrick<br>58 N. Chicago, Joliet 60431     | Antanas Razma<br>58 N. Chicago, Joliet 60431          |
| WILLIAMSON<br>Members: 31-Dist. No. 9   | George Murphy<br>Marion Mem. Hosp., Marion 62959         | Herbert V. Fine<br>110 N. Division, Carterville 62918 |
| WINNEBAGO<br>Members: 311-Dist. No. 1<br>Mrs. Johanna Lund<br>Exec. Sec. Adm.<br>310 N. Wyman<br>Rockford 61101 | James H. Topp<br>310 N. Wyman, Rockford 61101            | John English<br>310 N. Wyman, Rockford 61101          |
| WOODFORD<br>Members: 8-Dist. No. 2  | Joe C. Phifer<br>203 S. Main St., Eureka 61530           | James W. Riley<br>109 S. Major St., Eureka 61530      |

#### No Organized County Society

Johnson

Marshall

Putnam

Cass-Brown

Coles-Cumberland

Henry-Stark

Jefferson-Hamilton

Jersey-Calhoun

Morgan-Scott

Saline-Pope-Hardin

Will-Grundy

#### Joint County Societies

*A major portion of this listing will become obsolete as of January, 1975. An up-to-date listing will be published in the delegates handbook section of the March issue of the Illinois Medical Journal.*

### Chicago Medical Society

|   |   |
|---|---|
| President: Howard C. Burkhead<br>2650 Ridge, Evanston Hosp., Evanston 60201 | President: Roland R. Cross, Jr.<br>724 N. Oak Park Ave., Oak Park 60302   |
| AUX PLAINES BRANCH  | Secretary: Joseph C. Sherrick<br>303 E. Superior St., Chicago 60611       |
| President: Everett E. Nicholas<br>1111 Franklin, River Forest 60305         | NORTH SHORE BRANCH  |
| Secretary: Meredith B. Murray<br>414 South Oak Park Ave., Oak Park 60302    | President: Clarke W. Mangun Jr.<br>733 S. Greenwood, Park Ridge 60068     |
| CALUMET BRANCH  | Secretary: Cyril C. Wiggishoff<br>611 Briar Lane, Northfield 60094        |
| President: James A. K. Lambur<br>2055 W. Hopkins Place, Chicago 60620       | NORTHWEST BRANCH  |
| Secretary: Bernard P. Flaherty<br>3900 W. 95th Street, Evergreen Park 60642 | President: Jorge Tovar<br>3237 N. New England Ave., Chicago 60634         |
| DOUGLAS PARK BRANCH   | Secretary: Raymond J. Des Rosiers<br>320 Central Avenue, Wilmette 60091   |
| President: Kent F. Borkovec<br>175 Northwood Drive, Riverside 60546         | SOUTH CHICAGO BRANCH  |
| Secretary: Fabian S. Ostrowski<br>3601 S. Austin Blvd., Cicero 60650        | President: William S. Smith<br>1100 East 173rd Place, South Holland 60473 |
| ENGLEWOOD BRANCH  | Secretary: Douglas L. Foster<br>7531 S. Stony Island Ave., Chicago 60649  |
| President: Stanley Budrys<br>2751 West 51st St., Chicago 60632              | SOUTH SIDE BRANCH   |
| Secretary:<br>(To be announced)   | President: Kermit Mehlinger<br>4901 Drexel Blvd., Chicago 60615           |
| NORTH SUBURBAN BRANCH   | Secretary: Otto J. Keller<br>5825 S. Dorchester Ave., Chicago 60637       |
| President: Leon L. Ampel<br>2701 Oak Street, Northbrook 60062               | SOUTHERN COOK COUNTY BRANCH   |
| Secretary: James E. Vanderbosch<br>636 Church St., Evanston 60201           | President: Conrad J. Urban<br>2823 W. 173rd Street, Hazelcrest 60429      |
| IRVING PARK SUBURBAN BRANCH   | Secretary: William J. Marshall<br>Athenia Park Medical Bldg.              |
| President: George L. Lagorio<br>1625 Forest Drive, Glenview 60025           | 2601 Lincoln Highway, Olympia Fields, 60461                               |
| Secretary: Arthur Kunis<br>668 Diversey, Chicago 60614                      | STOCK YARDS BRANCH  |
| JACKSON PARK BRANCH   | President: Maurice M. Hoeltgen<br>4700 W. 95th Street, Oak Lawn 60453     |
| President: Richard Jones<br>4820 S. Kenwood, Chicago 60615                  | Secretary: Edwin J. Lukaszewski<br>1213 West 51st Street, Chicago 60609   |
| Secretary: Ralph F. Naunton<br>950 E. 59th Street, Chicago 60037            | WEST SIDE BRANCH  |
| NORTH SIDE BRANCH   | President: Eugene T. Hoban<br>6429 West North Ave., Oak Park 60302        |

President: Roland R. Cross, Jr.

724 N. Oak Park Ave., Oak Park 60302

Secretary: Joseph C. Sherrick

303 E. Superior St., Chicago 60611

NORTH SHORE BRANCH

President: Clarke W. Mangun Jr.

733 S. Greenwood, Park Ridge 60068

Secretary: Cyril C. Wiggishoff

611 Briar Lane, Northfield 60094

NORTHWEST BRANCH

President: Jorge Tovar

3237 N. New England Ave., Chicago 60634

Secretary: Raymond J. Des Rosiers

320 Central Avenue, Wilmette 60091

SOUTH CHICAGO BRANCH

President: William S. Smith

1100 East 173rd Place, South Holland 60473

Secretary: Douglas L. Foster

7531 S. Stony Island Ave., Chicago 60649

SOUTH SIDE BRANCH

President: Kermit Mehlinger

4901 Drexel Blvd., Chicago 60615

Secretary: Otto J. Keller

5825 S. Dorchester Ave., Chicago 60637

SOUTHERN COOK COUNTY BRANCH

President: Conrad J. Urban

2823 W. 173rd Street, Hazelcrest 60429

Secretary: William J. Marshall

Athenia Park Medical Bldg.

2601 Lincoln Highway, Olympia Fields, 60461

STOCK YARDS BRANCH

President: Maurice M. Hoeltgen

4700 W. 95th Street, Oak Lawn 60453

Secretary: Edwin J. Lukaszewski

1213 West 51st Street, Chicago 60609

WEST SIDE BRANCH

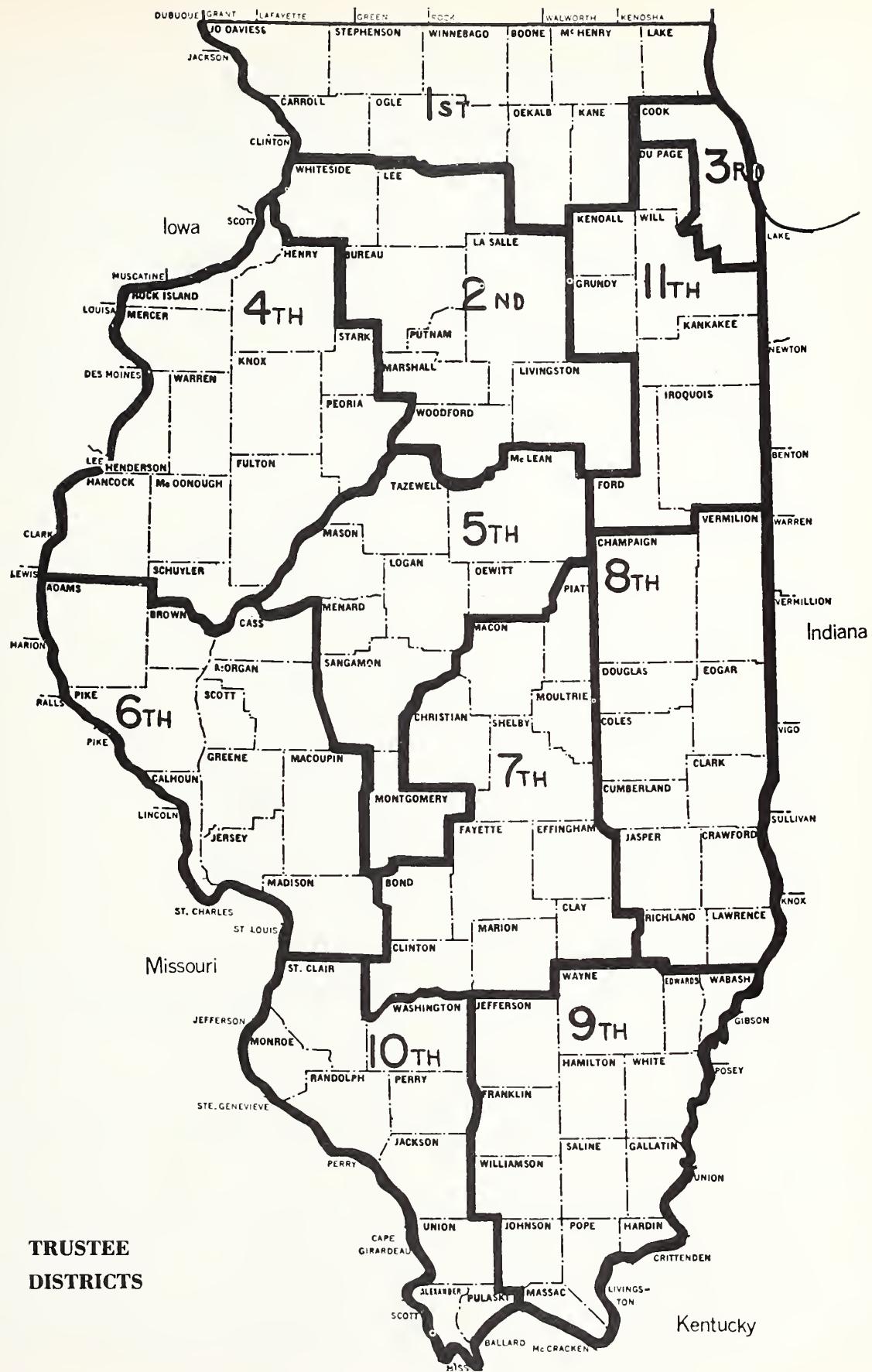
President: Eugene T. Hoban

6429 West North Ave., Oak Park 60302

Secretary: Henry Okner

6435 W. North Avenue, Oak Park 60302

## Wisconsin



## **TRUSTEE DISTRICTS**

## TRUSTEE DISTRICT COMMITTEES

### First District

Joseph L. Bordenave, Geneva, *Trustee*  
 Counties of Boone, Carroll, DeKalb, Jo Daviess, Kane,  
 Lake, McHenry, Ogle, Stephenson, Winnebago

|   | TERM    |   | TERM    |
|---|---------|---|---------|
| ETHICAL RELATIONS COMMITTEE                   | EXPIRES | ETHICAL RELATIONS COMMITTEE               | EXPIRES |
| John H. Steinkamp, Belvidere, <i>Chairman</i> | 1975    |   |         |
| Gerald Liesen, St. Charles                    | 1976    |   |         |
| A. M. Rosetti, McHenry                        | 1977    |   |         |
| Paul Burkholder, Rockford                     | 1975    |   |         |
|   |         |   |         |
| PEER REVIEW COMMITTEE                         |         | PEER REVIEW COMMITTEE                     |         |
| Robert Behmer, Rockford                       | 1977    | Russell Jensen, Monmouth, <i>Chairman</i> | 1976    |
| Charles Picus, Rockford                       | 1975    | William Daugherty, Moline                 | 1975    |
| Walter J. Reedy, Waukegan                     | 1975    | Donald Dexter, Macomb                     | 1977    |
| John E. Madden, Freeport                      | 1976    | G. W. Giebelhausen, Peoria                | 1975    |
| Rodney Nelson, Geneva                         | 1975    | James C. Parsons, Geneseo                 | 1976    |
| Erwin A. Schilling, Rockford                  | 1975    | Clarence Ward, Peoria                     | 1975    |
| R. E. Whitsitt, Rockford                      | 1975    |   |         |

### Second District

Allan L. Goslin, Streator, *Trustee*  
 Counties of Bureau, LaSalle, Lee, Livingston, Marshall,  
 Putnam, Whiteside, Woodford

|   | TERM    |   | TERM    |
|---|---------|---|---------|
| ETHICAL RELATIONS COMMITTEE                   | EXPIRES | ETHICAL RELATIONS COMMITTEE                     | EXPIRES |
| K. Dexter Nelson, Princeton, <i>Chairman</i>  | 1977    | William W. Curtis, Springfield, <i>Chairman</i> | 1977    |
| William Erkonen, Streator                     | 1975    | A. L. Van Ness, Bloomington                     | 1976    |
| Tim Sullivan, Sterling                        | 1976    | Jack Means, Mason City                          | 1975    |
|   |         |   |         |
| PEER REVIEW COMMITTEE                         |         | PEER REVIEW COMMITTEE                           |         |
| K. M. Nelson, Princeton, <i>Chairman</i>      | 1975    | James Borgerson, Mt. Pulaski, <i>Chairman</i>   | 1977    |
| M. D. Burnstine, Sterling, <i>Co-Chairman</i> | 1976    | Robert Price, Bloomington, <i>Co-Chairman</i>   | 1977    |
| James B. Aplington, LaSalle                   | 1976    | Paul Lafata, Springfield                        | 1977    |
| LaMonte Ballard, Sterling                     | 1976    | George Irwin, Bloomington                       | 1976    |
| Francis J. Brennan, Utica                     | 1976    | John C. Meyer, Springfield                      | 1975    |
| Silvio Davito, Spring Valley                  | 1976    | Alton J. Morris, Springfield                    | 1976    |
| Bernard J. Doyle, LaSalle                     | 1976    | Robert B. Perry, Lincoln                        | 1976    |
| Donald Edwards, Dixon                         | 1976    | Robert Schaefer, Petersburg                     | 1975    |
| William Ehling, Streator                      | 1977    | James Weimer, Pekin                             | 1976    |
| Julius Kolis, Dixon                           | 1976    |   |         |
| P. Lymberopoulos, Dixon                       | 1976    |   |         |
| Edward Murphy, Dixon                          | 1977    |   |         |
| Rowland Musick, Mendota                       | 1976    |   |         |
| Theodore Mauger, Chatsworth                   | 1975    |   |         |
| Louis Tarsinos, Princeton                     | 1976    |   |         |
| Theodore W. Wagenknecht, Streator             | 1976    |   |         |

### Third District

David S. Fox, Olympia Fields, *Trustee*  
 Robert T. Fox, Glenview, *Trustee*  
 Eugene T. Hoban, Oak Park, *Trustee*  
 Joseph Skom, Chicago, *Trustee*  
 William M. Lees, Lincolnwood, *Trustee*  
 George Shropshear, Chicago, *Trustee*  
 Philip G. Thomsen, Dolton, *Trustee*  
 Frederick E. Weiss, Harvey, *Trustee*  
 Warren Young, Crete, *Trustee*

### Fourth District

Fred Z. White, Chillicothe, *Trustee*  
 Counties of Fulton, Hancock, Henderson, Henry, Knox,  
 McDonough, Mercer, Peoria, Rock Island, Schuyler,  
 Stark, Warren

|  | TERM    |                             | TERM    |
|--|---------|-----------------------------|---------|
| ETHICAL RELATIONS COMMITTEE                  | EXPIRES | ETHICAL RELATIONS COMMITTEE | EXPIRES |
| Richard Icenogle, Roseville, <i>Chairman</i> | 1977    | John Bowman, Abingdon       | 1976    |
| George Burke, Rock Island                    | 1975    |                             |         |
|  |         |                             |         |
| PEER REVIEW COMMITTEE                        |         | PEER REVIEW COMMITTEE       |         |
| Russell Jensen, Monmouth, <i>Chairman</i>    | 1976    | William Daugherty, Moline   | 1975    |
| Donald Dexter, Macomb                        | 1977    | G. W. Giebelhausen, Peoria  | 1975    |
| James C. Parsons, Geneseo                    | 1976    | Clarence Ward, Peoria       | 1975    |

### Fifth District

A. Edward Livingston, Bloomington, *Trustee*  
 Counties of DeWitt, Logan, McLean, Mason, Menard,  
 Montgomery, Sangamon, Tazewell

|   | TERM    |   | TERM    |
|---|---------|---|---------|
| ETHICAL RELATIONS COMMITTEE                     | EXPIRES | ETHICAL RELATIONS COMMITTEE                   | EXPIRES |
| William W. Curtis, Springfield, <i>Chairman</i> | 1977    | A. L. Van Ness, Bloomington                   | 1976    |
| Jack Means, Mason City                          | 1975    |   |         |
|   |         |   |         |
| PEER REVIEW COMMITTEE                           |         | PEER REVIEW COMMITTEE                         |         |
| James Borgerson, Mt. Pulaski, <i>Chairman</i>   | 1977    | Robert Price, Bloomington, <i>Co-Chairman</i> | 1977    |
| Paul Lafata, Springfield                        | 1977    | George Irwin, Bloomington                     | 1976    |
| John C. Meyer, Springfield                      | 1975    | Alton J. Morris, Springfield                  | 1976    |
| Robert B. Perry, Lincoln                        | 1976    | Robert Schaefer, Petersburg                   | 1975    |
| James Weimer, Pekin                             | 1976    |   |         |

### Sixth District

Mather Pfeiffenberger, Alton, *Trustee*  
 Counties of Adams, Brown, Calhoun, Cass, Green, Jersey,  
 Macoupin, Madison, Morgan, Pike, Scott

|  | TERM    |   | TERM    |
|--|---------|---|---------|
| ETHICAL RELATIONS COMMITTEE                      | EXPIRES | ETHICAL RELATIONS COMMITTEE                   | EXPIRES |
| Newton DuPuy, Quincy                             | 1977    | Bernard Baalman, Hardin                       | 1975    |
| Edward K. DuVivier, Alton                        | 1977    | Joseph J. Grandone, Gillespie                 | 1977    |
| Lee Johnson, Staunton                            | 1975    |   |         |
|  |         |   |         |
| PEER REVIEW COMMITTEE                            |         | PEER REVIEW COMMITTEE                         |         |
| Robert R. Hartman, Jacksonville, <i>Chairman</i> | 1975    | Meyer Shulman, Pittsfield, <i>Co-Chairman</i> | 1977    |
| E. C. Bone, Jacksonville                         | 1976    | Edward Ragsdale, Alton                        | 1977    |
| Robert C. Murphy, Quincy                         | 1976    | Frank B. Norbury, Jacksonville                | 1975    |
| James Reid, Greenfield                           | 1977    | James W. Sutherland, Quincy                   | 1977    |
| A. D. Wilson, Carrollton                         | 1975    |   |         |

## **Seventh District**

Arthur F. Goodyear, Decatur, *Trustee*  
 Counties of Bond, Christian, Clay, Clinton, Effingham,  
 Fayette, Macon, Marion, Moultrie, Piatt, Shelby

| ETHICAL RELATIONS COMMITTEE | TERM<br>EXPIRES |
|-----------------------------|-----------------|
|-----------------------------|-----------------|

|   |      |
|---|------|
| Carl Sandburg, Decatur, <i>Chairman</i> ..... | 1976 |
| E. H. Rames, Vandalia .....                   | 1975 |

**PEER REVIEW COMMITTEE**

|  |      |
|--|------|
| Stanley Moore, Vandalia, <i>Chairman</i> ..... | 1976 |
| M. K. Kaufman, Greenville .....                | 1977 |
| H. Gale Zacheis, Decatur.....                  | 1977 |
| Walter P. Plassman, Centralia .....            | 1976 |
| William Sargeant, Effingham .....              | 1976 |

## **Eighth District**

Eugene P. Johnson, Casey, *Trustee*  
 Counties of Champaign, Clark, Coles, Crawford, Cum-  
 berland, Douglas, Edgar, Jasper, Lawrence, Richland,  
 Vermillion

| ETHICAL RELATIONS COMMITTEE | TERM<br>EXPIRES |
|-----------------------------|-----------------|
|-----------------------------|-----------------|

|  |      |
|--|------|
| Mack W. Hollowell, Charleston, <i>Chairman</i> ..... | 1977 |
| James H. Pass, Olney .....                           | 1975 |
| Alan M. Taylor, Danville .....                       | 1976 |

**PEER REVIEW COMMITTEE**

|  |      |
|--|------|
| E. T. Baumgart, Danville, <i>Chairman</i> .....  | 1977 |
| James W. Landis, Olney, <i>Co-Chairman</i> ..... | 1977 |
| E. A. Kendall, Mattoon .....                     | 1976 |
| George T. Mitchell, Marshall .....               | 1975 |
| Gordon Sprague, Paris .....                      | 1976 |

## **Ninth District**

Warren D. Tuttle, Harrisburg, *Trustee*  
 Counties of Edwards, Franklin, Gallatin, Hamilton, Har-  
 din, Jefferson, Johnson, Massac, Pope, Saline, Wabash,  
 Wayne, White, Williamson

| ETHICAL RELATIONS COMMITTEE | TERM<br>EXPIRES |
|-----------------------------|-----------------|
|-----------------------------|-----------------|

|  |      |
|--|------|
| Andrew Krajec, West Salem, <i>Chairman</i> ..... | 1976 |
| Antonio Boba, Mt. Vernon .....                   | 1977 |
| Elliott Partridge, Eldorado .....                | 1977 |

**PEER REVIEW COMMITTEE**

|   |      |
|---|------|
| C. J. Jannings, III, Fairfield, <i>Chairman</i> ..... | 1976 |
| Philip Boren, Carmi .....                             | 1977 |
| James Durham, Benton .....                            | 1975 |
| Herbert Fine, Carterville .....                       | 1975 |
| Ernest Lowenstein, Mt. Carmel .....                   | 1976 |
| Charles K. Wells, Mt. Vernon .....                    | 1975 |

## **Tenth District**

Herbert Dexheimer, Belleville, *Trustee*  
 Counties of Alexander, Jackson, Monroe, Perry, Pulaski,  
 Randolph, St. Clair, Union, Washington

| ETHICAL RELATIONS COMMITTEE | TERM<br>EXPIRES |
|-----------------------------|-----------------|
|-----------------------------|-----------------|

|   |      |
|---|------|
| A. L. Robinson, Mounds, <i>Chairman</i> ..... | 1976 |
| William Borgsmiller, Murphysboro .....        | 1975 |
| Peter Soto, Belleville .....                  | 1977 |

**PEER REVIEW COMMITTEE**

|  |      |
|--|------|
| Joseph A. Petrazio, Murphysboro, <i>Chairman</i> ..... | 1976 |
| Charles Baldree, Belleville .....                      | 1976 |
| Eli Borken, Carbondale .....                           | 1976 |
| R. W. Jost, Waterloo .....                             | 1975 |
| B. Kinsman, DuQuoin .....                              | 1976 |
| Robert Rader, Anna .....                               | 1977 |
| R. E. Schettler, Red Bud .....                         | 1977 |
| William H. Walton, Belleville .....                    | 1975 |
| Charles L. Yarbrough, Cairo .....                      | 1976 |

## **Eleventh District**

Ross N. Hutchison, Gibson City, *Trustee*  
 Counties of DuPage, Ford, Grundy, Iroquois, Kankakee,  
 Kendall, Will

| ETHICAL RELATIONS COMMITTEE | TERM<br>EXPIRES |
|-----------------------------|-----------------|
|-----------------------------|-----------------|

|   |      |
|---|------|
| James Ryan, Kankakee, <i>Chairman</i> ..... | 1975 |
| John Bowden, Joliet .....                   | 1976 |
| Lawrence D. Lee, Manhattan .....            | 1976 |

**PEER REVIEW COMMITTEE**

|  |      |
|--|------|
| James Campbell, Wheaton, <i>Chairman</i> ..... | 1975 |
| James E. Dailey, Watska .....                  | 1975 |
| James Lambert, Joliet .....                    | 1976 |
| Guy Pandola, Joliet .....                      | 1975 |
| William C. Perkins, West Chicago .....         | 1976 |
| A. G. Parkhurst, Kankakee .....                | 1977 |
| W. H. Brill, Oswego .....                      | 1977 |

## HOUSE OF DELEGATES

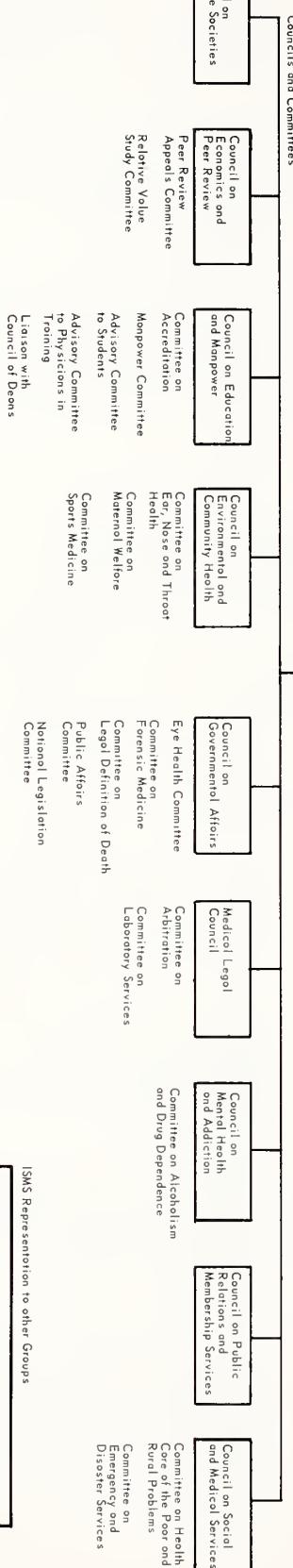
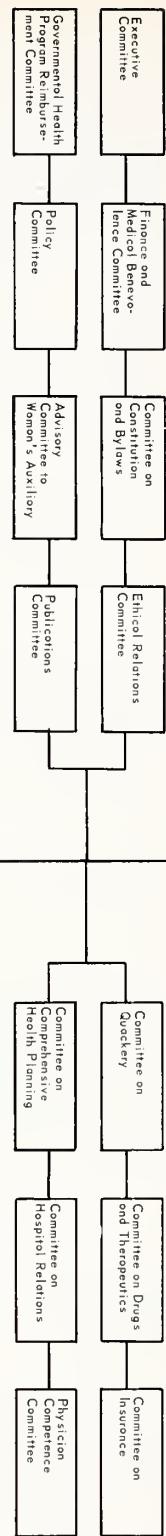
### BOARD OF TRUSTEES

Direct Reporting Committees

Committee on  
Redistricting  
and Tenure

Select Committee

Committees of the Board



Groups Related to ISMS

Illinois Foundation for Medical Care  
Illinois Council on Continuing Medical Education  
Representatives to the Annual Meeting Joint Management Committee  
Representatives to the Illinois Professional Standards Review Organization  
ISMS Education and Scientific Foundation  
Student Loan Fund Board

ISMS Representation to other Groups

SFW  
LTC  
MRLA  
SAMA  
CHA  
IIP  
EC  
DAI  
PCC  
JCSH  
ICP  
CP  
ISMS  
U.S. Pharmacopeia  
MOO  
CIC  
The Commission on Children

# Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board Committees. Some free standing committees may report directly to the board and may not be assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies. The President, President-Elect, Speaker of the House, and Chairman of the Board are, by virtue of their office, ex-officio members of all groups.

## COUNCIL ON AFFILIATE SOCIETIES

|   |  |
|---|--|
| Samuel Cloninger, <i>Chairman</i><br>Ill. Radiological Society<br>64 Old Orchard, Skokie 60076      | Robert C. Muehrcke<br>Ill. Chap., Amer. College of Phy.<br>518 N. Austin Blvd., Oak Park 60302   |
| Robert Bettasso<br>Ill. Chap., Amer. Coll. of Surgeons<br>1703 Polaris Circle, Ottawa 61350         | Simon Ramah<br>Ill. Society of Pathology<br>St. Bernards Hosp., 6337 S. Harvard, Chicago 60621   |
| Lawrence Breslow<br>Ill. Chap., Amer. Academy of Pediatrics<br>1500 Shermer Rd., Northbrook 60062   | Bill B. Smiley<br>Ill. Chap., Amer. Coll. of Emer. Rm. Phy.<br>2155 Hoyt Court, Decatur 62526  |
| Edward Brunner<br>Ill. Soc. of Anesthesiologists<br>303 E. Chicago Ave., Chicago 60611              | E. B. Sylvester<br>Ill. Section, Amer. Coll. of Ob-Gyn.<br>57 N. Ottawa, Joliet 60431  |
| Wm. B. Buckingham<br>Ill. Soc. of Internal Medicine<br>30 North Michigan, Chicago 60602             | <i>Alternates</i>  |
| James Burden<br>Chicago Urological Society<br>720 N. Michigan, Chicago 60611                        | Donald H. Hanscom<br>Ill. Soc. of Internal Medicine<br>40 So. Clay St., Hinsdale 60521   |
| Jan Fawcett<br>Ill. Psychiatric Society<br>1720 West Polk St., Chicago 60612                        | Robert M. Kark<br>Ill. Chap., Amer. Coll. of Phy.<br>1753 W. Congress, Chicago 60612   |
| Norman M. Frank<br>Ill. Chap., Amer. Academy of Family Phy.<br>421 Park Ave., Clarendon Hills 60514 | Albert L. Pisani<br>Ill. Chap., Amer. Academy of Pediatrics<br>40 So. Clay St., Hinsdale 60521   |
| Jack Gibbs<br>Ill. Surgical Society<br>175 Main St., Canton 61520                                   | <b>Responsibilities and Purposes:</b>  |
| David Helberg<br>Ill. Assoc. of Ophthalmology<br>1702 Washington St., Waukegan 60085                | To improve communication and provide liaison with the specialty societies; provide specialty consultation to other ISMS councils and committees; and to serve as a resource unit to ISMS on advances in the medical specialties. |
| W. R. Malony<br>Ill. Ob-Gyn. Society<br>Carbondale Clinic, Box 2347, Carbondale 62901               | STAFF: James Kopriwa   |

## COUNCIL ON ECONOMICS AND PEER REVIEW

|  |   |
|--|---|
| Robert J. Becker, <i>Chairman</i><br>229 N. Hammes, Joliet 60435 | Cyril C. Wiggishoff<br>25 E. Washington St., Chicago 60602                      |
| Theodore Donosky<br>800 S. Main, Benton 62812                    | Ben Williams<br>1400 W. Park Ave., Urbana 61801                                 |
| Earl E. Fredrick Jr.<br>10830 Halsted, Chicago 60628             | CONSULTANTS:<br>David S. Fox<br>20829 Greenwood Center Ct., Olympia Field 60461 |
| Homer Goldstein<br>Box 144, Libertyville 60048                   | Warren W. Young<br>3450 Haweswood Dr., Crete 60417                              |
| A. Beaumont Johnson<br>860 Summit, Elgin 60120                   | Eugene P. Johnson<br>P.O. Box 68, Casey 62420                                   |
| Michael Murray<br>1200 N. East, Olney 62450                      | PHYSICIAN-IN-TRAINING:<br>Ronald T. Staubly<br>419 N. 7th, Springfield 62701    |
| Luke R. Pascale<br>18668 Dixie Highway, Homewood 60430           | STUDENT REPRESENTATIVE:<br>Wayne Domin<br>829 Simpson St., Evanston 60201       |
| Maynard I. Shapiro<br>7531 Stony Island Ave., Chicago 60649      | STAFF: Joseph J. Lotharius  |
| Joseph Silverstein<br>1616 Sheridan Rd., Wilmette 60091          |   |

**Committees:**

Peer Review Appeals  
Relative Value Study

**Responsibilities and Purposes:**

The Council on Economics & Peer Review shall concern itself with: 1) relations with the health insurance

industry and prepayment plans; 2) fees and fee adjudication as promulgated by the ISMS; 3) health care cost and utilization; 4) new modes of health care delivery (HMOs, prepaid programs); 5) health care planning programs (CHP, IRMP, etc.), 6) serving as the appellate body for peer review in the state.

**PEER REVIEW APPEALS COMMITTEE***Council Members:*

Earl E. Fredrick, Jr., *Chairman*  
Theodore Donosky  
A. Beaumont Johnson  
Michael Murray  
STAFF: Joseph J. Lotharius

**Responsibilities and Purposes:**

The Peer Review Appeals Committee serves as the appellate body for peer review in the state. It considers cases being appealed from local or district Peer Review committees involving quality and quantity of medical care. The committee also serves as liaison to local peer review committees and offers its assistance whenever requested.

**RELATIVE VALUE STUDY COMMITTEE***Council Member:*

Ben Williams, *Chairman*

*Non-Council Members:*

Joseph L. D'Silva  
513 Kin Court, Wilmette 60091  
John L. Eaton  
2855-18th St., C, Moline 61265  
Clifton L. Reeder  
734 N. Merrill Ave., Park Ridge 60068

**CONSULTANT:**

Jacob E. Reisch  
1129 S. 2nd St., Springfield 62704  
STAFF: Joseph J. Lotharius

**Responsibilities and Purposes:**

The Committee's purpose is a positive effort to develop an Illinois relative value study.

**COUNCIL ON EDUCATION AND MANPOWER**

Morgan M. Meyer, *Chairman*  
815 S. Main, Lombard 60148  
Allison L. Burdick, Jr., *Vice Chairman*  
(*Adv. to Physicians-in-Training*)  
Carl R. Barthelemy  
175 S. Main, Canton 61520  
J. Ernest Breed  
(*Liaison to Illinois Council on CME*)  
55 E. Washington St., Chicago 60602  
George O. Dohrmann  
3000 W. Logan Blvd., Chicago 60647  
N. Kenneth Furlong  
221 N.E. Glen Oak Ave., Peoria 61603  
Larry C. Gunn  
40 So. Clay, Hinsdale 60521  
Lawrence L. Hirsch  
836 Wellington, Chicago 60657  
Forrest H. Riordan, M.D.  
5670 E. State, Rockford 61108  
Gonzalo Ruiz  
1937 N. Cleveland, Chicago 60614  
Joseph R. Shackelford  
562 Shaw, Paris 61944

**CONSULTANTS:**

Robert T. Fox  
2136 Robin Crest Lane, Glenview 60025  
Allan L. Goslin  
712 N. Bloomington, Streator 61364  
William M. Lees  
6518 N. Nokomis Ave., Lincolnwood 60646  
Fred Z. White  
723 N. Second St., Chillicothe 61523  
**INTERNS AND RESIDENTS:**  
Michael J. Hughey  
711 Laurel Ave., Wilmette 60091

**STUDENT REPRESENTATIVES:**

Alan Roman  
2121 Collette Lane, Flossmoor 60422  
William Yasnoff  
710 N. Lake Shore Dr., Chicago 60611

**REPRESENTATIVES OF MEDICAL SCHOOLS:**

*Chicago Medical School*  
James Shaffer  
2020 Ogden Ave., Chicago 60612  
*University of Chicago-Pritzker School of Medicine*  
Clifford W. Gurney  
950 E. 59th St., Chicago 60637  
*University of Illinois College of Medicine*  
Robert L. Evans  
1601 Parkview, Rockford 61101  
*Loyola University Stritch School of Medicine*  
William B. Rich  
2160 S. Ist, Maywood 60153  
*Northwestern Medical School*  
Jacob Suker  
303 E. Chicago Ave., Chicago 60611  
*Rush Medical School*  
John Graettinger  
Rush Presbyterian-St. Lukes Medical Center  
Chicago 60612  
*Southern Illinois University Medical School*  
Dax Taylor  
715 E. Carpenter, Springfield 62702  
STAFF: Philip Thomsen II

**Responsibilities and Purposes:**

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and re-

view programs for paramedical personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R&E, and review hospital oriented education programs. Liaison shall be maintained with the advisory committee to students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within

the scope of the Council, as well as medical licensure as it relates to education.

#### **Committees:**

Accreditation  
Liaison to Council of Deans  
Manpower  
Advisory Committee to Medical Students  
Advisory Committee to Physicians-in-Training

### **COMMITTEE ON ACCREDITATION**

#### *Council Members:*

N. Kenneth Furlong, *Chairman*

George O. Dohrmann

#### *Non-Council Members:*

John H. Huss

315 Schiller St., Elmhurst 60126

L. P. Johnson

1601 Parkview, Rockford 61101

Howard L. Lange

211 So. 3rd St., Belleville 62221

#### Rex O. McMorris

619 N.E. Glen Oak, Peoria 61603

STAFF: Philip G. Thomsen II

#### **Responsibilities and Purposes:**

To review survey reports of institutions which have applied for accredited status and grant accreditation to promote Continuing Medical Education activities; to provide liaison with the Illinois Council on Continuing Medical Education.

### **LIAISON COMMITTEE TO THE COUNCIL OF DEANS**

#### *Council Member:*

Morgan M. Meyer

#### *Governmental Affairs Council Representative:*

George T. Wilkins

3165 Myrtle Ave., Granite City 62040

#### *Illinois Council on Continuing Medical Education Representative:*

Dean R. Bordeaux

2421 W. Rohmann Ave., Peoria 61604

STAFF: Philip G. Thomsen II

### **MANPOWER SUBCOMMITTEE**

#### *Council Members:*

Lawrence L. Hirsch

Gonzalo Ruiz

#### *Non-Council Members:*

William R. Durham

203 North Vine St., Harrisburg 62946

Charles M. Maples

408 South Cross, Robinson 62454

#### *CONSULTANTS:*

Eugene Johnson

Casey Medical Center

P.O. Box 68, Casey 62420

Frederick E. Weiss

15643 Lincoln Ave., Harvey 60426

Fred Z. White

723 N. Second St., Chillicothe 61523

STAFF: Philip G. Thomsen II

### **ADVISORY COMMITTEE TO MEDICAL STUDENTS**

#### *Carl Barthelemy, Chairman*

175 S. Main St., Canton 61520

Larry Herron

542 Main St., Bridgeport 62417

Richard J. Jones

4920 S. Kenwood, Chicago 60615

Paul S. Reeder

1950 N. Water St., Decatur 62526

Forrest Riordan

6670 E. State St., Rockford 61108

Glen Tomlinson

4 Lincoln Professional Park, Lincoln 62656

Theodore R. Van Dellen

435 N. Michigan Ave., Chicago 60611

#### *STUDENT REPRESENTATIVES:*

J. Bob Achebe (*Rush*)

4930 S. Woodlawn, Chicago 60615

Margaret Donovan (*Loyola*)

1815 S. Wolf Rd., Hinsdale 60162

Lawrence Kanter (*U. Chicago*)

4800 S. Lake Park, Chicago 60615

David Rollins (*MECO*)

408 N. Taylor St., Apt. 3A, Oak Park 60302

Alan Roman (*Chicago Medical*)

2121 Colette Lane, Flossmoor 60422

Gary Stabler (*Chicago Osteopathic*)

327 S. Wisconsin St., Apt. 2B, Oak Park 30302

Jeff Waitzman (*Illinois*)

1431 W. Farwell, Chicago 60626

William Yasnoff (*Northwestern*)

710 N. Lake Shore Dr., Chicago 60611

STAFF: Perry Smithers

### **ADVISORY COMMITTEE TO PHYSICIANS-IN-TRAINING**

#### *Allison Burdick, Jr. Chairman*

1637 N. Mobile, Chicago 60639

James R. Buechler

410 N. Second St., Marshall 62441

Larry C. Gunn

40 S. Clay St., Hinsdale 60521

Vernon L. Zech

St. Therese Hospital, Waukegan 60685

#### *PHYSICIANS-IN-TRAINING:*

Edith Hartman

1601 W. Taylor St., Chicago 60612

Michael Hughey

711 Laurel Ave., Wilmette 60091

James J. McCoy  
643 N. Harvey, Oak Park 60302  
Marc Rose  
7401 N. Kostner, Skokie 60076  
Ronald T. Stauby  
320 N. 9th St., Springfield 62702

Barry Storter  
886 Cambridge, Buffalo Grove 60090  
Paul M. Stromborg  
1741 N. Neva, Chicago 60635  
Kong-Meng Tan  
521 W. Briar, Chicago 60657  
STAFF: Perry Smithers

## COUNCIL ON ENVIRONMENTAL AND COMMUNITY HEALTH

Julius M. Kowalski, *Chairman*  
(*Liaison with Environmental Groups*)  
436 Park Avenue E., Princeton 61356  
James P. Campbell  
322 N. Blanchard, Wheaton 60187  
William W. Curtis  
100 W. Miller, Springfield 62702  
Thomas Davison  
(*Liaison with Industrial Medicine*)  
17 N. Clinton St., Chicago 60606  
John S. Hipskind  
301 W. Lincoln, Belleville 62221  
Eduard Jung  
17030 So. Wausau Ave., South Holland 60473  
Daniel J. Pachman  
(*Liaison with Pediatric Coordinating Council*)  
1212 N. Lake Shore Drive, Chicago 60610  
Stephen E. Reid  
2500 Ridge Ave., Evanston 60201  
Richard C. Treanor  
1430 N. State Rd., Arlington Heights 60004  
William H. Weiss  
(*Liaison with EENT & Otolaryngology Soc.*)  
118 W. Laurel, Springfield 62704

### CONSULTANTS:

Byron Francis  
State of Illinois, Dept. of Public Health  
535 W. Jefferson St., Springfield 62761  
Robert R. Hartman  
1515A W. Walnut, Jacksonville 62650  
Edward A. Piszcak  
6410 N. Leona, Chicago 60646  
Warren W. Young  
11541 S. Champlain Ave., Chicago 60628

### INTERNS AND RESIDENT:

Barry M. Storter  
886 Cambridge Dr., Buffalo Grove 60090

## COMMITTEE ON EAR, NOSE AND THROAT HEALTH

*Council Member:*  
William H. Weiss, *Chairman*  
*Non-Council Members:*  
Andreas G. Kodros  
4640 N. Marine Drive, Chicago 60640  
R. Marcus  
64 Old Orchard—Suite 229, Skokie 60076  
Ralph F. Naunton  
950 E. 59th St., Box 412, Chicago 60637  
Guy O. Pfeiffer  
Link Clinic, 213 S. 17th St., Mattoon 61938

STAFF: Philip G. Thomsen II

### Responsibilities and Purposes:

The function of the Ear, Nose and Throat Health Committee is to concern itself with state legislation regarding Laryngological and Otological matters, to secure and disseminate information and make recommendations regarding specific legislative proposals. The Ear, Nose and Throat Health Committee shall also work in connection with the Chicago Laryngological and Otological Society.

## COMMITTEE ON MATERNAL WELFARE

William W. Curtis, *Chairman*  
**DISTRICTS MEMBERS AND ALTERNATES**  
(alternates in italics)  
1. William J. Weigel  
57 E. Downer Pl., Aurora 60506

Gerald F. Staub  
119 W. Union, Rockton 61072  
2. William J. Farley  
710 Peoria St., Peru 61354

*Donald M. Gallagher*  
Marshall-Putnam Clinic S.C.  
Granville 61326  
3. Melvin Goodman  
13826 Lincoln Ave., Dolton 60419  
*Charles F. Kramer*  
12647 S. Justin St., Calumet Park 60643  
4. V. B. Adams  
301 E. Jefferson, Macomb 61455  
*Ralph Gibson*  
416 St. Marks Ct., Peoria 61603  
5. William W. Curtis  
100 W. Miller, Springfield 62702  
*Robert Maletich*  
1025 S. 7th St., Springfield 62703  
6. Richard D. Yoder  
601 E. 3rd St., Alton 62002  
*Donald E. Hardbeck*  
2856 Beltline, Alton 62002  
7. Paul A. Raber  
149 W. King St., Decatur 62521  
*Hubert Magill*  
1170 E. Riverside, Decatur 62521  
8. John C. Mason, Jr.  
715 N. Logan, Danville 61832

*J. Roger Powell*  
Carle Clinic Association  
602 W. University Ave., Urbana 61801  
9. William B. Skaggs  
Doctor's Clinic  
203 N. Vine, Harrisburg 62946  
*Donald R. Risely*  
319 Market St., Mt. Carmel 62863  
10. Arthur A. Smith  
306 E. Eighth St., O'Fallon 62269  
*William J. Malony*  
Carbondale Clinic  
P.O. Box 2347, Carbondale 62901  
11. John J. McLaughlin  
2100 Glenwood Ave., Joliet 60435  
*Charles P. Westfall*  
172 Schiller, Elmhurst 60126  
CONSULTANTS:  
John Louis  
10721 S. Hoyne, Chicago 60643  
Willard C. Scrivner  
Suite #2, 6600 W. Main St., Belleville 62223  
Augusta Webster  
707 N. Fairbanks Ct., Chicago 60611  
Robert R. Hartman  
1515A Walnut St., Jacksonville 62650  
STAFF: Philip G. Thomsen II

#### AD-HOC COMMITTEE ON SPORTS MEDICINE

*Council Member:*  
Stephen E. Reid, *Chairman*  
*Non-Council Members:*  
Bernad R. Cahill  
416 St. Mark Ct., Peoria 61614  
Eugene F. Diamond  
11055 S. St. Louis Ave., Chicago 60655  
Robert C. Kirkwood  
Kensler Bldg., Lawrenceville 62439  
Donald Ross  
401 E. Springfield, Champaign 61820  
Howard J. Sweeny  
2500 Ridge Ave., Evanston 60201

CONSULTANT:  
J. M. Ingalls  
502 Shaw, Paris 61944  
STAFF: Philip G. Thomsen II

#### Responsibilities and Purposes:

The Committee's purpose is to promote safe, healthful athletic activities for all Illinois children. The Committee will encourage conferences and other programs to educate trainers and coaches on the proper handling of injuries and the physical and psychological problems of athletic participation by children. It will cooperate with programs which encourage high school students to consider training as a career.

#### GOVERNMENTAL AFFAIRS COUNCIL

George T. Wilkins, *Chairman*  
3165 Myrtle Avenue, Granite City, 62040  
James Laidlaw, *Vice-Chairman*  
Christie Clinic, 104 W. Clark, Champaign 61820  
Finley W. Brown, Jr.  
1445 N. State Parkway, Chicago 60610  
George H. Burke  
Rock Island Franciscan Hospital, 2701-17th,  
Rock Island 61201  
David J. Clark  
1780 W. Galena, Aurora 60506  
Alfred J. Faber  
2110 Swainwood Drive, Glenview 60025  
Edward G. Ference  
932 S. Second, Springfield 62704  
Frank J. Jirka, Jr.  
1507 Keystone, River Forest 60305  
Warren W. Kretf  
940 Lee Street, Des Plaines 60016  
John W. Ovitz  
204 W. Elm Street, Sycamore, 60178  
Elliott Partridge  
1201 Pine Street, Eldorado 62930  
Robert Pierce  
1415 E. State Street, Rockford 61108

CONSULTANTS:  
Robert Fox  
2136 Robin Crest, Glenview 60025  
J. M. Ingalls  
502 Shaw, Paris 61944  
Eugene Johnson  
P.O. Box 68, Casey 62420  
William M. Lees  
6518 N. Nokomis, Lincoln 60646  
Willard C. Scrivner  
Suite 2, 6600 W. Main, Belleville 62223  
Mrs. Pam Taylor  
1607 N. Vermilion, Danville 61832  
Philip G. Thomsen  
13826 Lincoln Avenue, Dolton 60419

#### STUDENT REPRESENTATIVE:

John Hall  
12 Harrison Street, Oak Park

#### AUXILIARY REPRESENTATIVE:

Mrs. Alton (Sharon) Morris  
1616 Leland, Springfield

STAFF: Don Udstuen

#### Responsibilities and Purposes:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of

citizens of Illinois and the practice of medicine in Illinois.  
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.  
3. Co-operate with the AMA in similar programs.  
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

#### Committees:

Eye Health  
Forensic Medicine  
Legal Definition of Death  
National Legislation Committee  
Public Affairs

#### EYE HEALTH COMMITTEE

*Council Member:*  
Warren W. Kreft, *Chairman*

*Non-Council Members:*

Frederick Crowley  
117 Bellemount Road, Bloomington 61701  
Maurice M. Hoeltgen  
1836 West 87th St., Chicago 60620  
Paul Hauser  
2500 Ridge Ave., Evanston 60201

Edward Kwedar  
615 S. 7th, Springfield 62703  
Samuel Schall  
30 N. Michigan, Chicago 60602  
Frank Snell  
334 West Main, Decatur 62522  
Robert W. Webb  
213 South Charles, Edwardsville 62025  
STAFF: Don Udstuen

#### AD HOC COMMITTEE ON FORENSIC MEDICINE

Grant C. Johnson  
Memorial Hospital, First and Miller Street,  
Springfield 62705  
Thomas P. DeGraffenreid  
1208 Sunnymead, DeKalk 60115  
Victor Levine  
Apt. 801, 1700 E. 56th Street, Chicago 60637  
Donal D. O'Sullivan  
Augustana Hospital, 411 W. Dickens, Chicago 60614

James H. Ryan  
401 N. Wall, Kankakee 60901  
Karl Sohlberg  
Methodist Hospital, Peoria 61605  
Robert Stein  
2926 Arlington Avenue, Highland Park 60035  
Robert Wissler  
950 E. 59th Street, Chicago 60637  
STAFF: Don Udstuen

#### COMMITTEE ON LEGAL DEFINITION OF DEATH

Jacob E. Reisch, *Chairman*  
1129 S. 2nd St., Springfield 62704  
Thomas Baffes  
Dept. of Surgery, Mt. Sinai Hospital  
2755 W. 15th St., Chicago 60608  
Benjamin Boshes

303 E. Chicago, Chicago 60611  
William Dye  
3200 Highland, Downers Grove 60515  
Fred Merkel  
151 Sheridan Road, Kenilworth 60643  
STAFF: Don Udstuen

#### NATIONAL LEGISLATION COMMITTEE

*Council Members:*  
George T. Wilkins, *Chairman*  
Alfred J. Faber  
Frank J. Jirka, Jr.  
James Laidlaw  
Elliott Partridge  
*CONSULTANTS:*  
Joseph L. Bordenave  
1665 South Street, Geneva 60134  
Fredric D. Lake  
1041 Michigan Avenue, Evanston 60202  
William M. Lees  
6518 N. Nokomis, Lincolnwood 60646

P. John Seward  
1601 Parkview, Rockford 61107  
STAFF: Don Udstuen

#### Responsibilities and Purposes:

The National Legislation Committee was formed in 1974 at the request of the Board of Trustees. Its purpose is to study national legislative proposals which have impact on the health care delivery system in Illinois and to promulgate proposals designed to improve the quality of health care and the practice of medicine in Illinois. The Committee will also serve as a source of information to ISMS members on the status of such proposals.

#### PUBLIC AFFAIRS COMMITTEE

*Council Members:*  
Elliott Partridge, *Chairman*  
Robert Pierce, *Vice Chairman*  
Finley W. Brown, Jr.  
James Laidlaw  
John W. Ovitz  
George T. Wilkins  
*Non Council Members:*  
Theodore F. Bartlett  
7447 Pottawatomi Drive, Palos Heights 60463  
Louis Dondanville  
501-15th Street, Moline 61265

Joseph Hinkamp  
1775 Glenview Road, Glenview  
Earl V. Klaren  
158 E. Cook Street, Libertyville 60048  
Frank J. Kresca  
208 W. Green Street, Champaign 61820  
Paul Mahon  
326 N. 7th, Springfield 62701  
Thomas P. Meirink  
8601 W. Main, Belleville 62223  
George T. Mitchell  
Cork Medical Center, 410 N. 2nd, Marshall 62441

Tassos Nassos  
3929 N. Central, Chicago 60634  
Donal D. O'Sullivan  
Augustana Hospital, 411 W. Dickens, Chicago 60614  
Albert W. Ray, Jr.  
301 N. Reed Street, Joliet 60435  
David Rendleman  
Box 2347, Carbondale 62901  
James H. Ryan  
401 N. Wall, Kankakee 60901

A. E. Steer  
701 N. Walnut, Bldg. A, Springfield 62707  
Lorin D. Whittaker  
840 Jefferson Building, Peoria 61602  
**AUXILIARY REPRESENTATIVE**  
Mrs. Stanley (Barbara) Burris  
1630 Wiggins Ave., Springfield 62704  
**STAFF:** Bob Kjellander

#### MEDICAL LEGAL COUNCIL

Leonard Klafta, *Chairman*  
57 W. Jefferson, Joliet 60431  
James Habegger, *Vice Chairman*  
(*Laboratory Services*)  
32 S. Lincoln, Geneva 60134  
Herman Wing (*IMT*)  
836 W. Wellington, Chicago 60645  
Donal D. O'Sullivan  
(*Interprofessional Code*)  
411 W. Dickens, Chicago 60614  
William Schwingel  
(*Arbitration*)  
1240 N. Highland Ave., Aurora 60506  
Marshal Segal  
650 Wrightwood, Chicago 60614  
Eli Tobias  
1330 Braeburn Rd., Flossmoor 60422  
Constantine Veremakis  
409 E. Park Dr., Belleville 62223  
Eugene Vickery  
202 S. Schuyler, Lena 61048  
Arnold Wagner  
2500 Ridge, Evanston 60201  
**CONSULTANTS:**  
Jacob E. Reisch  
1129 S. Second St., Springfield 62704  
Allan Goslin  
712 N. Bloomington, Streator 61634  
Herbert Dexheimer  
301 S. Illinois, Belleville 62223  
James Fletcher, Esq.  
c/o Burditt and Calkins,

135 S. LaSalle St., Chicago 60603  
**STUDENT REPRESENTATIVE:**  
David Hopp  
5715 S. Drexel, Chicago 60637  
**PHYSICIAN-IN-TRAINING REPRESENTATIVE:**  
Marc Rose  
7401 N. Kostner, Skokie 60076  
**STAFF:** Richard A. Ott

#### Responsibilities and Purposes:

The Medical Legal Council shall cooperate with all organizations interested in medico-legal problems in order to educate members of the profession in medico-legal affairs.

This council shall maintain liaison with the Illinois Bar Association and cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Testimony panel. The stated objective of the panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

The council shall effect methods of elevating and maintaining the standards of medical laboratories in Illinois and encourage the use of medical diagnostic laboratories supervised by duly qualified physicians. In addition, the council shall be concerned with standards of practice and quackery.

#### Committees:

Arbitration  
Impartial Medical Testimony  
Laboratory Services

#### COMMITTEE ON ARBITRATION

*Council Member:*  
William Schwingel, *Chairman*  
*Non-Council Members:*

Clinton Compere  
233 E. Erie, Chicago 60611  
David T. Petty  
316 N. Michigan, Chicago 60601

Vincent Sarley  
682 Pine, Deerfield 60015  
**STAFF:** Richard A. Ott

#### Responsibilities and Purposes:

The committee shall review alternatives available to the medical profession in amelioration of professional liability litigation; to this end it is engaged in establishing pilot projects for screening panels, arbitration or other activities.

#### COMMITTEE ON LABORATORY SERVICES

*Council Member:*  
James Habegger, *Chairman*  
*Non-Council Members:*  
Coye Mason  
4720 W. Montrose, Chicago  
Richard Novak  
1601 Parkview, Rockford  
Bernard Stodsky  
4824 N. Karlov, Chicago  
Earl Suckow  
617 Glendale, Mt. Prospect 60056  
Victor Aydt  
Paris Community Hospital, Paris 61944

Joseph O. Dean, Jr.  
Proctor Hospital, Peoria 61604  
**STAFF:** Richard A. Ott

#### Responsibilities and Purposes:

The committee shall effect methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians and encourage each county and district to establish evaluation committees. It will cooperate with various state agencies in promoting a safe, adequate blood supply for the state.

## COUNCIL ON MENTAL HEALTH AND ADDICTION

S. Dale Loomis, *Chairman*  
923 W. Wellington, Chicago  
J. Richard Gallagher  
1330 N. Lake, Aurora 60506  
Ronald Shlensky  
251 E. Chicago, Suite 930, Chicago 60611  
Howard D. Kurland  
636 Church St., Evanston 60201  
Donovan Wright  
135 S. Kenilworth, Elmhurst 60126  
W. David Steed  
(*Alcoholism and Drug Dependence*)  
1011 Lake St., Suite 423-4, Oak Park 60301  
Thomas W. Stach  
620 Oakbrook Prof. Bldg., Oak Brook 60521  
Albert W. Ray, Jr.  
(*Drug Misuse Education*)  
301 N. Reed, Joliet 60435  
Warren R. Dammers  
203 N. Vine St., Harrisburg 62946  
Robert Nunn  
(*IPS Liaison*)  
180 N. Michigan Ave., Chicago 60601  
**CONSULTANTS:**  
Joseph Skom  
707 N. Fairbanks Ct., Chicago  
LeRoy Levitt, *Director*  
Illinois Dept. of Mental Health  
160 N. LaSalle St., Chicago 60601

**STUDENT REPRESENTATIVE:**  
Connie Wehling  
2234 N. Seminary, Chicago

**PHYSICIAN-IN-TRAINING REPRESENTATIVE:**  
Edith Hartman  
1601 W. Taylor, Chicago

**AUXILIARY MEMBER:**  
Mrs. H. Frank Holman  
302 Paddock Rd., Belleville 62223

**STAFF:** Richard A. Ott

**Committees:**  
Alcoholism and Drug Dependence

### Responsibilities and Purposes:

This council shall serve as a source of information on mental health matters for ISMS, evaluate information and make recommendations to the Board of Trustees on positions ISMS should take on issues in this area, and cooperate with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse.

The council shall be on the alert for misleading or fallacious programs and information and recommend appropriate action. It shall also be concerned with reviewing legislation related to the field of mental health, alcoholism, drug abuse, and hazardous substances.

## COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

**Council Members:**  
W. David Steed, *Chairman*  
Albert Ray, Jr.  
(*Education Programs*)  
**Non-Council Members:**  
Charles Anderson  
120 N. Oak, Hinsdale 60521  
Kermitt Mehlinger  
4901 Drexel Blvd., Chicago 60615  
George Silvest  
Lowell Park Rd., Dixon 61021  
James West  
2800 W. 95th St., Evergreen Pk. 60642  
George Stanton  
55 E. Washington Blvd., Chicago 60602  
**CONSULTANTS:**  
Edward Senay, IDAP  
1440 S. Indiana, 3rd floor, Chicago 60605

Joseph Skom  
707 N. Fairbanks Ct., Chicago 60611  
**STAFF:** Richard A. Ott

### Responsibilities and Purposes:

The Committee shall work closely with public and private agencies on projects aimed at eliminating the misuse of alcohol and drugs. The committee's functions will include: (1) study, research and dissemination of educational information on drugs and alcohol to members of the medical profession; (2) cooperate in the dissemination of information on the causes, prevention, diagnosis and treatment of alcoholism and drug dependence to the medical profession and to the public; (3) recommend acceptable measures for control of distribution and disposal of drugs and hazardous substances, exclusive of radiation products, and (4) to cooperate with official and non-official agencies in all matters pertaining to this subject.

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## COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Paul J. Biedenharn, *Chairman*  
Medical Arts Building, New Baden 62265  
Alan Taylor, *Vice-Chairman*  
1012 W. Fairchild, Danville 61832  
Robert Boxer  
64 Old Orchard Rd., Skokie 60076  
Catherine Dobson  
5842 Stony Island Ave., Chicago 60037  
Bruce G. Fagel  
619 Drexel, Glencoe 60022

Robert Hamilton  
25 E. Washington St., Chicago 60602  
Mack W. Hollowell  
35 Circle Drive, Charleston 61920  
A. J. Kiessel  
1800 E. Lake Shore Drive, Decatur 62521  
Charles W. Pfister  
5511 N. Harlem Ave., Chicago 60656  
**CONSULTANTS:**  
Robert T. Fox  
2136 Robin Crest Lane, Glenview 60025

Robert R. Hartman  
1515A W. Walnut, Jacksonville 62650  
J. M. Ingalls  
502 Shaw Ave., Paris 61944  
Jacob E. Reisch  
1129 S. 2nd St., Springfield 62704  
**AUXILIARY REPRESENTATIVE:**  
Mrs. Donovan Stiegel (Betty)  
2920 15th Ave., Moline 61265  
**STAFF:** Edward Stuppy

#### **Responsibilities and Purposes:**

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socio-economic programs believed to be in the best interest of the profession as well as the general public. The council shall be responsible for new member orientation, exhibits and public service programming.

### **COUNCIL ON SOCIAL AND MEDICAL SERVICES**

James C. Reid, *Chairman*  
712 S. College, Greenfield 62044  
Paul V. Banning  
410 N. 2nd, Marshall 62441  
Jerry L. Beguelin  
Box 197, Irvington  
James S. Berry  
1036 W. Stephenson St., Freeport 61032  
John W. Bowden  
330 Madison, Joliet 60435  
Audley F. Connor  
3233 S. King Dr., Chicago  
Ralston R. Hannas  
1558 W. Fork Dr., Lake Forest 60045  
Kenneth A. Hurst  
157 S. Lincoln, Aurora 60505  
Robert P. Johnson  
108 Maple Grove, Springfield 62707  
Max Klinghoffer  
127 E. Vallette, Elmhurst 60126  
Aaron M. Rosenthal  
1775 Dempster Ave., Park Ridge 60068  
Sheldon S. Waldstein  
222 E. Superior St., Chicago 60611

**CONSULTANT:**  
Fred Z. White  
723 N. 2nd St., Chillicothe 61523  
**STUDENT REPRESENTATIVE:**  
Rick Wender  
901 S. Ashland, Chicago 60607  
**PHYSICIAN-IN-TRAINING:**  
Paul Stromborg  
1741 N. Neva, Chicago 60635  
**STAFF:** Larry Boress

#### **Committees:**

Committee on Health Care of the  
Poor and Rural Problems  
Committee on Emergency and Disaster Care  
Sub-Committee on Aging

#### **Responsibilities and Purposes:**

The Council on Social and Medical Services shall initiate and implement programs related to health care facilities, hospital services, emergency room and disaster medical care; maintain liaison with the nursing profession and other health-oriented organizations, including the Illinois Department of Vocational Rehabilitation; handle problems related to aging, rural health and health care of the poor.

### **COMMITTEE ON EMERGENCY AND DISASTER CARE**

*Council Members:*  
Max Klinghoffer, *Chairman*  
Ralston R. Hannas, Jr., *Vice Chairman*

*Non-Council Members:*

David Allan  
14 Peninsula Rd., Lake Villa 60046  
Earl Donelan  
2425 S. Glenwood Ave., Springfield 62704  
Bill B. Smiley  
2115 Hoyt Ct., Decatur 62526  
**CONSULTANTS:**  
Eugene P. Johnson  
P.O. Box 68, Casey 62420

Allan L. Goslin  
712 N. Bloomington, Streator 61364  
Fredrick E. Weiss  
15643 Lincoln, Harvey 60426  
**STAFF:** Larry S. Boress

#### **Responsibilities and Purposes:**

This committee is concerned with improving the delivery of health care in emergency situations. The committee will monitor the effectiveness of emergency medical service programs as they exist throughout the state. It will also assist local and state agencies to evaluate new programs in emergency and disaster health care.

### **SUB-COMMITTEE ON AGING**

*Council Members:*  
John W. Bowden, *Chairman*  
Kenneth A. Hurst  
Robert P. Johnson  
**CONSULTANTS:**  
Bertram B. Moss  
Illinois Department of Public Health  
1919 W. Taylor, Chicago 60612  
Larsandrew Dolan  
6016 N. Nina, Chicago 60631

Stanley R. Palutsis  
360 Fairbank Rd., Riverside 60546  
Mr. Herman Gruber  
AMA, 535 N. Dearborn, Chicago 60610  
**STAFF:** Larry S. Boress

#### **Responsibilities and Purposes:**

The Committee is to act as a liaison between the medical profession and the Illinois Department of Aging. It is concerned with the quality of care provided in nursing facilities, and the environment surrounding the non-institutional elderly.

## COMMITTEE ON HEALTH CARE OF THE POOR AND RURAL PROBLEMS

### *Council Members:*

Audley F. Connor, Jr., *Chairman*  
Jerry L. Beguelin  
James S. Berry  
*Non-Council Members:*  
Helen C. Bonbrest  
1455 N. Sandburg Ter., Chicago 60610  
Raymond R. Clemens  
2100 Glenwood, Joliet 60435  
John L. Froiland  
6101 N. Sheridan Rd., Chicago 60660  
Eugene Gaertner  
1908 St. Charles Rd., Maywood 60153  
Alfred D. Klinger  
5229 S. Woodlawn, Chicago 60616  
Lloyd E. Thompson  
4601 State St., East St. Louis 62205

### **CONSULTANTS:**

Fred Z. White  
723 N. 2nd St., Chillicothe 61523  
Mr. Gary B. Schwartz  
AMA Health Care of the Poor  
535 N. Dearborn, Chicago 60610  
Mr. Carmello Rodriguez, ASPIRA  
767 N. Milwaukee, Chicago 60622  
Mrs. Lois Kortemeier, Woman's Auxiliary  
1443 W. Woodside, Freeport 61032

### **STAFF:** Larry S. Boress

### **Responsibilities and Purposes:**

The committee's responsibility is to mobilize and utilize the resources of the medical profession to achieve available and acceptable health care for the poor and for those living in rural areas.

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## Committees of the Board of Trustees

### COMMITTEE ON CONSTITUTION AND BYLAWS

A. Edward Livingston, *Chairman*  
326 Fairway Drive, Bloomington 61701  
Herbert Dexheimer  
301 S. Illinois, Belleville 62220  
David S. Fox  
20829 Greenwood Center Ct., Olympia Fields 60461  
George Shropshire  
1525 E. 53rd St., Chicago 60615  
Warren D. Tuttle  
203 N. Vine St., Harrisburg 62946  
**CONSULTANTS:**  
Andrew Brislen  
6060 Drexel Ave., Chicago 60637  
James Fletcher, Esq.  
Burditt & Calkins, 135 So. LaSalle St., Chicago 60603

### **STAFF:** Perry Smithers

### **Responsibilities and Purposes:**

The Committee on Constitution & Bylaws shall:

- 1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution & Bylaws;
- 2) Prepare for the consideration of the House of Delegates, all changes in the Constitution & Bylaws; and
- 3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

The Speaker of the House of Delegates shall be an ex-officio member of this committee.

### ETHICAL RELATIONS COMMITTEE

Joseph Skom, *Chairman*  
707 Fairbanks Ct., Chicago 60611  
Arthur Goodyear  
142 E. Prairie, Decatur 62523  
Eugene T. Hoban  
6429 North Ave., Oak Park 60302  
Frederick E. Weiss  
15643 Lincoln, Harvey 60426  
**STAFF:** James Slawny

### **Responsibilities and Purposes:**

The responsibilities and purposes of this committee are outlined in CHAPTER XI. DISCIPLINE, Part 2 *Illinois State Medical Society Procedures*.

Section 1. Illinois State Medical Society Ethical Relations Committee. The Board of Trustees shall appoint from its members an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and By-laws of the Illinois State

Medical Society or its component societies and charges of misconduct of members of the Society.

Section 2. Appeals from Component Society Verdicts. Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board of review. (Appeals must be accompanied by a comprehensive stenographic record of the proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the accused "not guilty.") The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. Verdict. The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent

evidence any interested party desires to present, and at the conclusion of the trial, the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

**Section 4. Notification and right of appeal.** The secretary of the Society shall notify the defendant and the secre-

tary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

## EXECUTIVE COMMITTEE

Joseph L. Bordenave, *Chairman*  
1665 South St., Geneva 60134  
Fredric D. Lake  
1041 Michigan Ave., Evanston 60202  
J. M. Ingalls  
502 Shaw Ave., Paris 61944  
Mather Pfeiffenberger  
State and Wall Streets, Alton 62002  
Allan L. Goslin  
712 N. Bloomington, Streator 61364  
Jacob E. Reisch  
1129 S. 2nd St., Springfield 62704  
William M. Lees  
6518 N. Nokomis, Lincolnwood 60646  
Harold A. Sofield  
715 Lake St., Oak Park 60301  
Willard C. Scrivner  
Suite 2, 6600 W. Main, Belleville 62223  
**STAFF:** Roger N. White

### Responsibilities and Purposes:

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large and the immediate past chairman of the Board provided he is still a Trustee.

**It may be given authority to act by the Board of Trustees.**

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

## FINANCE COMMITTEE AND MEDICAL BENEVOLENCE

Mather Pfeiffenberger, *Chairman*  
State & Wall Streets, Alton 62002  
Jacob E. Reisch  
1129 South 2nd Street, Springfield 62704  
Robert Fox  
2136 Robin Crest, Glenview 60025  
Ross N. Hutchison  
126 East Ninth St., Gibson City 60936  
**STAFF:**  
Roger N. White  
Richard D. Hengl

### Responsibilities and Purposes:

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for

the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Determine the allotment for each recipient.
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

## COMMITTEE ON GOVERNMENTAL HEALTH PROGRAM REIMBURSEMENT

Philip G. Thomsen, *Chairman*  
13826 Lincoln, Dolton 60419  
Herbert Dexheimer  
301 S. Illinois, Belleville 62220  
Eugene P. Johnson  
P.O. Box 68, Casey 62420  
William M. Lees  
6518 N. Nokomis, Lincolnwood 60646  
Frederick E. Weiss  
15643 Lincoln, Harvey 60426

Fred Z. White  
723 N. 2nd St., Chillicothe 61523  
**CONSULTANT:** Jacob E. Reisch  
**STAFF:** Joseph J. Lotharius

### Responsibilities and Purposes:

The responsibilities of the Committee on Governmental Health Program Reimbursement will be to consider all problems of physician reimbursement by the government health programs—Medicare, Medicaid, MEDICHEK and CHAMPUS.

## POLICY COMMITTEE

Allan L. Goslin, *Chairman*  
712 N. Bloomington, Streator 61364

Warren D. Tuttle  
203 N. Vine St., Harrisburg 62946

David S. Fox  
20829 Greenwood Center Ct., Olympia Fields 60461

STAFF: Perry Smithers

### Responsibilities and Purposes:

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

## PUBLICATIONS COMMITTEE

Jacob E. Reisch, *Chairman*  
1129 S. Second St., Springfield 62704

Warren W. Young  
3450 Haweswood Dr., Crete 60417

Eugene T. Hoban  
6429 North Ave., Oak Park 60302

James A. McDonald  
13 S. Second St., Geneva 60134

A. Edward Livingston  
326 Fairway, Dr., Bloomington 61761

STAFF: Richard A. Ott

### Responsibilities and Purposes:

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal*

and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

## ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

J. M. Ingalls, *Chairman*  
502 Shaw Avenue, Paris 61944

Fredric D. Lake  
1041 Michigan Avenue, Evanston 60202

Joseph L. Bordenave  
1665 South Street, Geneva 60134

STAFF: Roger N. White

### Responsibilities and Purposes:

The committee shall consist of the president-elect as chairman, the president, the chairman of the Board. The committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members.

## Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees will be formed from time to time, at the time of publication the following groups had been established.

## ANNUAL MEETING JOINT MANAGEMENT COMMITTEE

Harold A. Sofield, *Chairman*  
715 Lake St., Oak Park 60301

Joseph L. Bordenave  
1665 South St., Geneva 60134

C. Larkin Flanagan  
505 N. Lake Shore Dr., Chicago 60611

Vincent C. Freda  
4600 N. Ravenwood Ave., Chicago 60640

James A. McDonald  
13 S. 2nd St., Geneva 60134

Jacob E. Reisch  
1129 S. Second St., Springfield 62704

Andrew Thomson  
1725 W. Harrison St., Chicago 60612

Fred Z. White  
723 N. Second St., Chillicothe 61523

STAFF: Perry Smithers

### Responsibilities and Purposes:

The committee, consisting of equal numbers of representatives of the Chicago Medical Society and ISMS members outside of Cook County is responsible for the overall management of the Midwest Clinical Conference, which

is co-sponsored annually by the two organizations, in cooperation with various medical specialty groups. This committee establishes broad policy for the convention, including the setting of dates and place for the meeting,

decides on the general format of the program, delineates the areas of responsibility for the major co-sponsoring organizations, and oversees the budget for the conference.

#### COMMITTEE ON COMPREHENSIVE HEALTH PLANNING

**John J. Ring, Chairman**  
511 E. Hawley, Mundelein 60060  
**A. G. Baxter**  
34 N. Water, Batavia 60510  
**James B. Borgerson**  
119 S. Vine St., Mt. Pulaski 62548  
**Charles J. Jannings**  
301 N.W. 11th, Fairfield 62837  
**James R. Kennedy**  
401 N. Wail, Kankakee 60901  
**Ervin E. Nichols**  
1 E. Wacker Dr., Suite 2700, Chicago 60601  
**Joseph R. O'Donnell**  
444 Park, Glen Ellyn 60137

**Byron Ruskin**  
Memorial Hospital, Mattoon 61938  
**Irwin A. Smith**  
1141 Church, Northbrook 60062  
**STAFF:** Joseph J. Lotharius

##### Responsibilities and Purposes:

The ISMS CHP Committee was re-established to keep physicians abreast of all developments in the area of health planning and to encourage a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State CHP Agency and the areawide "b" agencies.

#### COMMITTEE ON DRUGS AND THERAPEUTICS

**Arthur R. Marks, Chairman**  
101 E. Center St., Fairfield 62837  
**Richard L. Landau**  
950 E. 59th St., Chicago 60637  
**Andrew Kraje**  
108 W. South St., West Salem 62476  
**Richard H. Suhs**  
1409 Stevenson Drive, Springfield 62703  
**William T. Gogan**  
7623 W. 63rd St., Summit 60501  
**Charles Salesman**  
Box 426, Paris 61944  
**Vincent A. Costanzo, Jr.**  
7531 S. Stony Island, Chicago 60649  
**Thomas William Lester**  
2017 W. 107th St., Chicago 60643

**CONSULTANT:**  
**Louis Gdalman, R.Ph.**  
5418 S. East View Park, Chicago 60615  
**STAFF:** Mrs. Pat Uznanski

##### Responsibilities and Purposes:

The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from the members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

#### COMMITTEE ON HOSPITAL RELATIONS

**Matthew B. Eisele, Chairman**  
4501 N. Park Dr., Belleville 62223  
**Raphael M. Adelman**  
1202 Oak Trail Dr., Libertyville 60048  
**Alfred Clementi**  
1320 Haddington Ct., Palatine 60067  
**Charles G. Farnum, Jr.**  
221 N.E. Glen Oak, Peoria 61603  
**Charles J. Weigel**  
7579 Lake St., River Forest 60305

**CONSULTANT:**  
**David S. Fox**  
20829 Greenwood, Olympia Fields 60461  
**STAFF:** James R. Slawny

##### Responsibilities and Purposes:

To develop informational materials and programs which will assist physicians in drafting and revising hospital medical staff bylaws.

#### COMMITTEE ON INSURANCE

**Philip D. Boren, Chairman**  
S. Plum St., Carmi 62821  
**Martin Compton**  
3003 E. Oakland Ave., Bloomington 61701  
**Lawrence Knox**  
1200 N. East St., Olney 62450  
**Theodore LeBoy**  
917 Norwood Dr., Melrose Park 60160

**Charles W. Schlagater**  
2950 Payne Ave., Evanston 60201  
**CONSULTANTS:**  
**David S. Fox**  
826 E. 61st St., Chicago 60637  
**A. Everett Joslyn**  
557 Keystone Ave., River Forest 60305

Jacob E. Reisch  
1129 S. Second St., Springfield 62704

STAFF: Perry L. Smithers

**Responsibilities and Purposes:**

The Committee on Insurance will review society-sponsored insurance programs, which are currently the Tax

Qualified Retirement Program (Keogh Plan), Retirement Investment Program, Group Disability Program, Business Overhead Expense Insurance, Group Major Medical Program, Hospital Benefit Program, Group Life Insurance and Professional Liability Insurance Program. The committee will study these plans, make suggestions for changes, additions and cancellation of policies, and investigate other insurance programs that may benefit society members.

### PHYSICIAN COMPETENCE COMMITTEE

Thomas W. Stach, *Chairman*  
Williams M. Lees, *Vice-Chairman*  
6518 N. Nokomis Ave., Lincolnwood 60646  
Willard C. Scrivner  
Suite #2, 6600 W. Main St., Belleville 62223  
Fredric D. Lake  
1041 Michigan Avenue, Evanston 60202

J. M. Ingalls  
502 Shaw, Paris 61944  
George T. Wilkins  
3165 Myrtle, Granite City 62040  
STAFF: Philip G. Thomsen II

### COMMITTEE ON QUACKERY AND UNAUTHORIZED PRACTICE OF MEDICINE

William M. Lees, *Chairman*  
6518 N. Nokomis, Lincolnwood 60646  
Charles Daisey  
308 College, Greenville 62246  
Robert Prentice  
2248 Warsen Rd., Springfield 62704  
Phillip Haggerty  
1409 Stevenson, Springfield 62703  
Richard Treanor  
1430 N. State Rd., Arlington Heights 60004  
STAFF: Richard A. Ott

**Responsibilities and Purposes:**

To function as an educational and monitoring group; to maintain awareness of cultist activities and initiate action to blunt these; to monitor education and registration activities to eliminate cultist frauds upon the public; to provide expert testimony as necessary regarding the difference between scientific medicine and cultists. Cultist groups initially of concern to the committee include chiropractic, naturopathy, naprapathy, scientology. In addition, the committee shall be on guard against the unauthorized practice of medicine by licensed or registered health care professionals who exceed the scope of practice allowed by their licensing acts, and shall coordinate this appropriately with other ISMS committees.

## Other Appointments and Representatives

### REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Donald Stehr, *Chairman*  
102 E. Market, Havana 62644  
Jack Gibbs  
175 S. Main St., Canton 61520  
Charles Salesman  
1 Laurel Lane, Paris 61944  
CONSULTANT:  
Jacob E. Reisch  
1129 S. 2nd St., Springfield 62704

STAFF: Perry L. Smithers

**Purpose:**

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

### INA-ISMS JOINT PRACTICE COMMITTEE

Bernard H. Adelson  
595 Lincoln, Glencoe 60022  
Fred Z. White  
723 N. 2nd St., Chillicothe 61523

Robert M. Reardon  
1008 N. Main St., Bloomington 61701  
J. M. Ingalls  
502 Shaw, Paris 61944  
STAFF: Philip G. Thomsen II

### OTHER REPRESENTATIVES

SWANBERG FOUNDATION, QUINCY  
Arkell M. Vaughn  
9012 S. Leavitt, Chicago 60620  
LONG TERM CARE ADVISORY COUNCIL TO IDPH  
Robert P. Johnson  
108 Maple Grove, Springfield 62707

MIDWEST REGIONAL LIBRARY ASSOCIATION  
H. Close Hesseltine  
5807 S. Dorchester, Chicago 60637  
LIAISON TO ILL. SOC. OF THE AMER. ASSOC.  
OF MED. ASSTS.  
Carl E. Clark  
225 Edward St., Sycamore 60178

ILLINOIS COUNCIL OF HOME HEALTH AGENCIES

Francis Bihs

4601 State, E. St. Louis 62205

CHICAGO ALLIANCE FOR VD AWARENESS

Edward Piszczek

6410 N. Leona, Chicago 60646

BAR ASSOCIATIONS INTERPROFESSIONAL CODE

Donal O'Sullivan

411 W. Dickens, Chicago 60614

Marshall Segal

650 Wrightwood, Chicago 60614

COUNCIL ON EFFICIENCY OF HEALTH CARE

Eugene P. Johnson

P.O. Box 68, Casey 62420

James Laidlaw

Christie Clinic, Champaign 61820

Joseph R. O'Donnell

444 Park, Glen Ellyn 60137

Fred A. Tworoger

4753 Broadway, Chicago 60640

DRUG ABUSE COUNCIL OF ILLINOIS

George Shropshear

1525 E. 53rd St., Chicago 60615

Joseph Skom

707 N. Fairbanks, Chicago 60611

PEDIATRIC COORDINATING COUNCIL

Daniel Pachman

1212 N. Lake Shore, Chicago 60605

JOINT COMMITTEE ON SCHOOL HEALTH

Richard E. Dukes

Carle Clinic, Urbana 61801

Willard W. Fullerton

101 N. Market, Sparta 62286

ILL. INTERAGENCY COUN. ON SMOKING AND DISEASE

Peter G. Gilbert

116 Sophia St., West Chicago 60185

THE ILLINOIS COMMITTEE FOR PERINATAL HEALTH/

PERINATAL MORALITY

Robert R. Hartman

1515A W. Walnut, Jacksonville 62650

William R. Larsen

13707 W. Jackson, Woodstock 60098

ISMS/IPS PEER REVIEW CONSULTING COMMITTEE

Alex Spadoni, *Chairman*

2301 Glenwood, Joliet 60435

Howard D. Kurland

636 Church St., Evanston 60201

S. Dale Loomis

700 N. Michigan, Chicago 60611

Marshall Falk

4700 N. Clarendon, Chicago 60640

Donovan G. Wright

135 S. Kenilworth, Elmhurst 60126

U.S. PHARMACOPEIA

Joseph Skom

707 N. Fairbanks, Chicago 60611

MD COMMITTEE ON OPTOMETRY

Warren Kreft

940 Lee St., DesPlaines 60016

Samuel Schall

30 N. Michigan, Chicago 60602

SCHOOL HEALTH PHYSICALS TASK FORCE—CHP

Julius Kowalski

436 Park Ave. East, Princeton 61356

Charles J. Jennings, *Alternate*

R.R. #4, Fairfield 62837

STATEWIDE COOPERATION ORGANIZATIONS OF THE  
COMMISSION ON CHILDREN

Daniel Pachman

1212 N. Lake Shore, Chicago 60605

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## ISMS House of Delegates Committees

### SELECT COMMITTEE

J. M. Ingalls, *Chairman*

502 Shaw, Paris 61944

C. Larkin Flanagan

720 N. Michigan, Chicago 60611

David S. Fox

20829 Greenwood Center Ct., Olympia Fields 60461

Jack L. Gibbs

175 S. Main, Canton 61520

Robert R. Hartman

1515A W. Walnut, Jacksonville 62650

Lawrence L. Hirsch

836 Wellington, Chicago 60657

Ross N. Hutchison

126 E. 9th St., Gibson City 60936

Richard J. Jones

4820 S. Kenwood, Chicago 60615

B. Franklin Lounsbury

707 N. Fairbanks, Chicago 60615

Jack Means

116 E. Elm St., Mason City 62664

Joseph B. Moles

715 Lake St., Oak Park 60301

James C. Parsons

648 N. Chicago, Genesco 61254

Alan Spector, Student

2228 W. Estes, Chicago 60645

Ronald T. Staubly, Resident

320 N. 9th, Springfield 62702

Andrew Thomson

1725 W. Harrison, Chicago 60612

Fred Z. White

723 N. 2nd St., Chillicothe 61523

George T. Wilkins

3165 Myrtle, Granite City 62040

CONSULTANT:

Fredric D. Lake

1041 Michigan, Evanston 60202

### Responsibilities and Purposes:

The mission of the Select Committee of the House of Delegates is to investigate the following matters and to report upon them, with appropriate recommendations, to the House of Delegates at its Annual Meeting in 1975:

1. The respective roles of and relationship between

ISMS and component societies.

2. The sources of conflict between certain component societies and ISMS, on both professional and staff levels.

3. The governance of the Society and its components—including consideration of: (a) Establishing a minimum size necessary to qualify as a component; (b) The advisability of creating more regional societies to replace county societies in more sparsely populated areas; (c) Redistricting and reapportionment of representation in the House of Delegates and the Board of Trustees; and (d) Tenure of officers, delegates, trustees and AMA dele-

4. The administration of the Society's affairs, including gates.

(a) The Council and Committee structure and missions; (b) The desirability of creating stronger district organizations and decentralizing some or all of the medical society's operations; and (c) The integration of activities of state and county societies.

5. The relationship of ISMS to Illinois Professional Standards Review Organization, Illinois Foundation for Medical Care and Illinois Council on Continuing Medical Education, especially in regard to the role of ISMS in the governance of these satellites.

#### SUBCOMMITTEE ON REDISTRICTING

John J. Ring, *Chairman*  
511 E. Hawley St., Mundelein 60060  
Julian W. Buser  
6600 W. Main, Belleville 62223  
E. Newton DuPuy  
1842 Grove, Quincy 62301  
C. Larkin Flanagan  
720 N. Michigan, Chicago 60611  
Jere E. Freidheim  
3050 Wallace, Chicago 60616  
Aaron B. Gerber  
23450 Western, Park Forest 60466

Lawrence L. Hirsch  
836 Wellington, Chicago 60657  
Wayne N. Leimbach  
1240 N. Highland, Aurora 60506  
Eugene T. Leonard  
1215 N. Alpine, Rockford 61107  
Warren D. Tuttle  
203 N. Vine, Harrisburg 62946  
CONSULTANTS:  
Fredric D. Lake  
1041 Michigan, Evanston 60202  
J. M. Ingalls  
502 Shaw, Paris 61944

## ISMS SERVICES

### Pursuit of Obligations

CONSTITUTIONAL PURPOSES OF THE ILLINOIS STATE MEDICAL SOCIETY ARE:

- to promote the science and art of medicine
- to protect the public health
- to evaluate standards of medical education
- to unite the medical profession behind these purposes
- to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

To fulfill these purposes, the Society maintains a headquarters office at 360 N. Michigan Ave., Chicago, and an office in Springfield at 520 S. Sixth St. In 1975 the headquarters office was lo-

cated at 55 East Monroe, Chicago, 60603. Services of the Society, under the general supervision of Roger N. White, Executive Administrator, are conducted by the following divisions:

Administration; Public Relations and Membership Services; Governmental Affairs; Publications and Scientific Services; Education and Manpower; and Health Care Delivery.

Many and varied are the activities of the Society in pursuit of its obligations. Some of these activities are major programs of statewide (and sometimes national) interest for all citizens; others are of special interest to doctors; still others are sponsored for specific groups or individuals.

Following are general descriptions of the Society's divisions and the programs, services and publications available directly to Society members or sponsored for their benefit.

### DIVISION OF ADMINISTRATION

The Executive Administrator has the responsibility and the authority to provide for the smooth and efficient functioning of the Illinois State Medical Society.

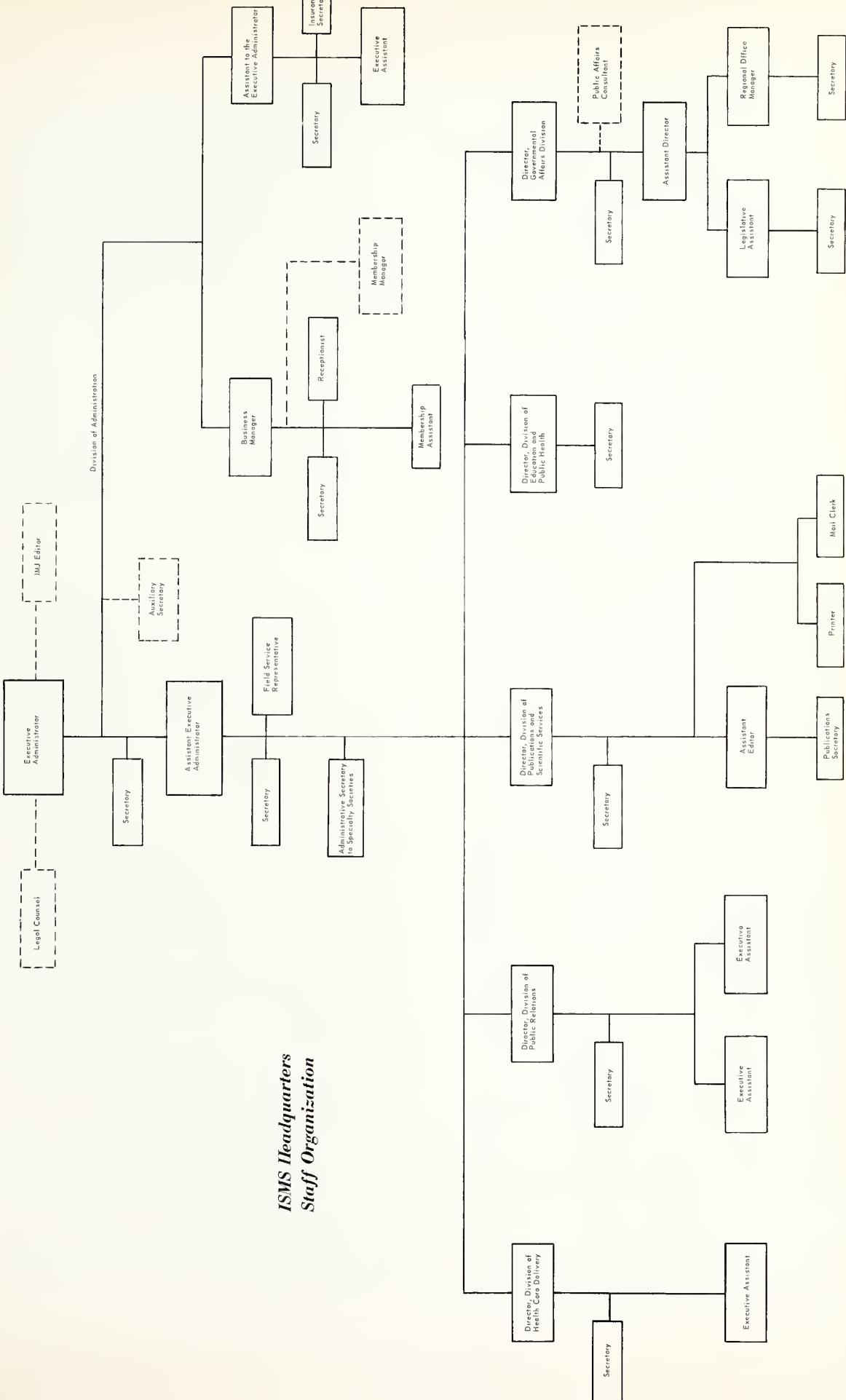
The implementation of established policy, fiscal and budgetary matters, the employment of qualified personnel and the development and maintenance of personnel policies are all part of the Administrator's activities.

He maintains liaison with the Board of Trustees and assists the chairman in carrying out his duties. Close cooperation with the Speaker of the

House of Delegates and the officers of the Society provides a smooth and efficient atmosphere in which the Society may function. Cooperation is maintained with the Committee on Constitution and Bylaws to present to the House all suggested changes for official action. The Administrator channels all legal inquiries and works with the General Legal Counsel to provide guidance to the officers, trustees, committee chairmen and county medical society officers.

To provide the membership of the Society with  
*(Continued on page 322)*

## ISMS Headquarters Staff Organization



the best professional staff services available, headquarters has been set up by divisions.

The Assistant Executive Administrator serves within this Division as a coordinator for the programs operated by other Divisions. Further coordination between the programs of the State Society and the County Medical Societies is achieved through a Field Services Representative working under the direction of the Assistant Executive Administrator.

The Society sponsored insurance programs, benevolence programs, travel tours for members, physician placement programs, student loan fund

program and all activities concerning the annual meeting are handled within the Division by the Assistant to the Executive Administrator.

The accounting and business service functions of the Society are handled by the Business Manager as a part of this Division. The Division also maintains the membership records and provides a computerized central dues billing and collection center for county medical societies. The Society's accounting and membership records are handled in close coordination with the Secretary-Treasurer under policies laid down by the Finance Committee and the Board of Trustees.

## DIVISION OF EDUCATION, MANPOWER AND PUBLIC HEALTH

The Division of Education, Manpower and Public Health was established in response to the growing demands created by the rapid changes in the education and utilization of physicians and other health care personnel. A primary responsibility of the Division is to maintain information on the changes in medical education. The Division works in concert with the AMA in keeping abreast of changes in medical school curriculae, and in postgraduate medical education.

In addition, the Division attempts to maintain current information on the training and use of such ancillary personnel as nurse practitioners and physician's assistants. New and innovative uses of personnel are studied and recommendations made to the ISMS Board of Trustees as to their appropriateness and legality. All information maintained by the Division is, of course, available to all ISMS members.

A second major responsibility in the Division is the field of public health. Liaison is maintained with the

Illinois Department of Public Health, and problems of the membership are relayed to the Department. In addition, ISMS services are coordinated with the Department whenever these are in a joint field of venture. Immunization programs and screening programs for hypertension and other physical problems are examples of the areas of cooperation between ISMS and IDPH.

The Division is responsible for matters of medical licensure other than illegal practice, and maintains liaison with the Illinois Department of Registration and Education to ensure that any licensure problems may be handled expeditiously.

The Division is responsible for the staffing of the Council on Education and Manpower, the Council on Environmental and Community Health, and the committees on Maternal Welfare, Sports Medicine, Ear Nose and Throat Health, Manpower, CME Accreditation, the Liaison Committee to the Council of Deans, the Physician Competence Committee, and the Joint Practice Committee.

## GOVERNMENTAL AFFAIRS DIVISION

As professional medicine strives to maintain the vigorous condition of the public health, the profession is vitally and intimately concerned with legislative actions of the Illinois General Assembly and the U. S. Congress which affect physicians, other members of the healing arts, and the lay public. To insure that the best health interests of the public and professional interests of the physician are served, the Division monitors all state and national legislation which affect the health of the individual and his community.

The monitoring process is designed to present the thoughtful views of professional medicine in Illinois on specific medically related pieces of legislation.

The ISMS Governmental Affairs Council acts as the clearing house for legislative proposals recommended by specialized ISMS committees; generated by allied groups; produced by special interests and introduced by representatives and senators. Such legislation is thoroughly analyzed by physician-members of the specialized ISMS committee covering the subject matter of the introduced legislation.

### Support or Oppose Legislation

Upon appropriate consideration and recommendation, legislation of medical significance in the Illinois Legisla-

ture is either supported or opposed to protect and promote the interests of the public and the profession. Pertinent subject matter testimony is presented before the House and Senate committees as the bill proceeds through the legislative process.

On-the-scene surveillance of monitored legislation is maintained by ISMS legislative representatives.

Through these essential actions, ISMS plays a meaningful role in shaping legislation for the betterment of the people of Illinois.

Action similar to the above is taken with respect to bills in Congress when they have special significance to Illinois physicians. This activity is conducted in concert with the American Medical Association.

Integrated with and designed to augment the legislative activity is the Public Affairs Program. The ISMS Public Affairs Committee strives to alert the physician to his role in public affairs and to involve him in effective participation in public affairs in his community, state, and nation.

### Other Activities

The division also staffs the committees on Public Affairs, Eye Health, Forensic Medicine, Legal Definitions of Death, and National Legislation Committee.

## DIVISION OF HEALTH CARE DELIVERY

The Division of Health Care Delivery was established because of the many important and complex socio-economic issues currently facing medicine.

A primary responsibility of the division is keeping ISMS members abreast of these socio-economic issues that have such impact on the delivery of health care. The division has expanded its activities in researching the many new types of health care programs being proposed or in varying stages of development throughout the state. Such pertinent socio-economic information will be disseminated to ISMS members through articles in the *Illinois Medical Journal* and "Action Report," and through special programs. During the past year the division has also worked with the Illinois Foundation for Medical Care.

The division staffs the Council on Economics & Peer Review and its committees on Peer Review Appeals and Relative Value Study. Principal duties of the council concern relations with the health insurance industry, government health programs, Comprehensive Health Planning agencies and regional medical programs. The Peer Review Appeals Committee serves as the appellate body for all disputed cases initially considered by local or district

peer review committees. The Relative Value Study Committee's task is to develop an Illinois relative value study.

The Division also staffs the Council on Social & Medical Services. This council initiates and implements programs related to health care facilities, hospital services, and emergency room and disaster medical care. It also maintains liaison with other health related organizations such as vocational rehabilitation, aging, health care of the poor, and rural health. Committees of the Council on Social & Medical Services include: Health Care of the Poor & Rural Problems and Emergency & Disaster Care.

In addition, the division staffs the Committee on Governmental Health Program Reimbursement that serves as liaison to Medicare, Medicaid, MEDICHEK and CHAMP-US in any matters regarding physician reimbursement by these programs; and the Comprehensive Health Planning Committee that serves as liaison to the Comprehensive State Health Planning Agency and the areawide "b" agencies. Finally, the Division of Health Care Delivery attends the Illinois Department of Public Aid's Medical Advisory Committee as an observer.

## DIVISION OF PUBLIC RELATIONS and MEMBERSHIP SERVICES

The Division of Public Relations functions both as a news outlet to the media and as a source of information to the membership.

Staff members prepare speeches and produce pamphlets and other materials on a wide variety of medical topics. They serve as consultants on public relations and publicity to county societies and also maintain liaison with state and private agencies in the health field and with allied associations.

The division is contacted almost daily by medical and scientific news writers who are obligated to provide timely information to a public that is increasingly interested in the many phases of health care.

The proliferation in recent years of health agencies at every level of government has brought the additional staff duty of "keeping up" with the activities of these agencies and reporting to the membership.

Beyond these traditional public relations duties, the division has initiated a number of special and highly successful projects. A few of them are:

*Journalism Awards* . . . are given annually for "distinguished achievement in medical journalism" in a variety of categories covering all media. The presentation program is thoroughly professional and the winners value the awards as a sincere recognition of their own efforts to inform the public.

*President's Tour* . . . takes the President of ISMS to each of the 11 Districts and gives him a chance to meet and discuss medical matters with physicians throughout the state. The president also holds press conferences and visits local media for interviews during the tour.

*Action Report* . . . is a publication which keeps members informed of current developments on such vital issues as malpractice problems and PSRO. The report also covers legislative and socio-economic events affecting the livelihood of all physicians.

*Dr. Sims Health Tips* . . . provide Illinois radio stations with a series of health tips for use seven days a week all year. "Dr. Sims Talks to Teens" is a monthly column on health advice printed in more than 400 high school newspapers.

*Radio-TV Speakers Bureau* . . . obtains physician speakers for discussion of general medical subjects, or for special interviews on critical issues of the day.

*Legislator TV Interviews* . . . supplies the state's TV stations during sessions of the General Assembly with sound-on-film segments of the views of legislators on pending health bills. This accomplishes the triple purposes of publicizing ISMS; establishing contacts with key TV station personnel; and maintaining good relationship with the legislators involved.

## DIVISION OF PUBLICATIONS AND SCIENTIFIC SERVICES

### Publications

Total production of all printed materials and publications, as well as their distribution, is this division's responsibility, except for distribution of items to selected specific groups. All printing and duplicating services are furnished either through an in-plant shop or outside services through competitive bidding. Modern reproduction and collating equipment allows for profes-

sional, commercial-quality production.

In addition, all mail room services are provided by this division. An addressograph and graphotype are utilized as well as a small wing mailer, folder and stuffer, and plate burning cabinets. Mailings are accomplished through computer-supplied labels and the addressograph.

Principal among the publications of the society is the official organ, the *Illinois Medical Journal*. The *Journal* is mailed monthly to all members, as well as other selected individuals, who are urged to read it to keep abreast of the scientific, economic, political, legal and social developments within the state, as such pertain to the practice of medicine. The editor welcomes suggestions for articles which may be of special interest to the membership. All members should consider the *IMJ* a means of communicating with fellow Illinois practitioners.

"Action Report" is an in-house publication totally produced in the ISMS print shop. Special publications, brochures, flyers, pamphlets, letters and cards as required by the several ISMS divisions to carry forth their mission, are produced.

## Advertising

Commercial advertising is carried within the *Illinois Medical Journal*. The maintenance of the records of advertisers, insertion orders, contracts, and direct communication and liaison with advertising agencies and pharmaceutical houses fall within the purview of the division. This furnishes opportunity of presenting a product to members of ISMS through advertising in ISMS publications.

## Other Services

Liaison is maintained with many governmental and voluntary agencies to guarantee an awareness of current activities and to have medicine's voice heard. An ongoing scheduling of meetings of committees provides opportunity for addressing many concerns in mental health, addictions, medical-legal, and laboratory services. The division, in addition, attempts to have expert information available to the members.

Needs of groups affiliated with or ancillary to ISMS, insofar as reproduction or distribution services are concerned, are also handled through the division office.

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## FILM

### Modern Management of Multiple Births

"Modern Management of Multiple Births" is a 16 mm. sound-color motion picture produced by the Educational and Scientific Foundation of the Illinois State Medical Society in cooperation with Lederle Laboratories Division of American Cyanamid Co.

Teaching "heart" of the film is step-by-step reconstruction of an elaborate protocol which serves as a standard of prenatal planning for any physician faced with the management of

multiple pregnancy.

For added teaching interest, the film reviews birth of identical quadruplets, showing how identicity was established with major and minor blood typings, examination of placenta and fetal membranes and other procedures. There are also scenes of actual delivery of quadruplets.

Showings of the film are restricted to professional audiences. Organizations may borrow the film from Lederle Laboratories Film Library, Pearl River, N. Y., or from the Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

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## SPECIAL PUBLICATIONS

### Action Report

"Action Report" is a bi-weekly newsletter published by the Illinois State Medical Society. It is distributed to members upon request. Purpose of the report is to alert physicians to important events or activities affecting the practice of medicine.

A short deadline ensures that important news is disseminated to the physicians as quickly as possible so that appropriate responses may be made.

### On the Legislative Scene

Emanating from the Springfield Regional Office is a weekly newsletter, "On the Legislative Scene," published during the weeks the General Assembly is in session.

This is produced by the Governmental Affairs Division and distributed upon request. It includes up-to-the-minute status reports on pending legislation of vital concern to medicine in Illinois. This well-received periodical has permitted immediate response by ISMS representatives in Springfield to

specific bills and has alerted physicians to the need for involvement in public affairs.

### Oral Contraceptive Forms

Legal consent forms for use when dispensing birth control pills are available to ISMS members. ISMS Trustees asked that the forms be prepared and made available because of adverse court decisions against physicians prescribing the pill.

Use of the consent forms is optional with each physician.

### Medical Career Recruitment Programs

The Woman's Auxiliary of the ISMS has been the spearhead force in Illinois to interest and recruit the youth of the state in medical careers. Members are asked to aid this effort by investigating the possibility of conducting or participating in career days in their home communities.

A paperback book entitled "Horizons Unlimited" is available from the American Medical Association.

## SCIENTIFIC SPEAKERS BUREAU

The Illinois State Medical Society, through its Scientific Speakers Bureau, aids county societies in their efforts to keep members abreast of medical advances by conducting postgraduate medical education programs in their own areas. This assistance includes obtaining speakers, preparing and mailing notices of meetings, and paying an honorarium and travel expenses. ISMS can also provide publicity services upon request.

It also pays a \$50 honorarium and expenses for individual speakers obtained by county medical societies for their regular meetings.

The Bureau operates under a grant from Merck, Sharpe & Dohme, which provides funds to the ISMS Educational and Scientific Foundation for the specific purpose of obtaining speakers for county medical society meetings.

The following procedures govern use of the Bureau:

- 1) County societies select speakers from a

roster containing the names of more than 400 speakers and over 1,000 topics.

2) Eight weeks advance notice is required for postgraduate meetings. Requests for such meetings, which usually are scheduled for an entire afternoon, should be sent to the Scientific Speakers Bureau, Illinois State Medical Society, 360 N. Michigan Ave., Chicago.

3) Publicity to media in the area of the meeting will be handled by ISMS upon request of the county society.

4) Postcard notices will be mailed to physicians in the county if requested. ISMS will prepare and mail notices if the information is received no less than three weeks prior to the meeting.

5) The county medical society program chairman and the speaker are both expected to submit to ISMS a report on the meeting and the arrangements.

## PHYSICIAN RECRUITMENT & STUDENT LOAN FUND PROGRAMS

The Illinois State Medical Society not only offers help to students who wish to become physicians, but also is able to assist the careers of those already licensed to practice medicine.

The society provides this aid through two special activities. First is its own Physician Recruitment Program & Doctor's Job Fair. Second is the Illinois Medical Student Loan Fund Program that the society sponsors in conjunction with the Illinois Agricultural Association.

### PHYSICIAN RECRUITMENT PROGRAM

The Physician Recruitment Program is designed to help physicians find a desirable area in which to establish practice or to relocate. The program's purpose is twofold, since it is interested also in helping those communities which demonstrate need of a resident physician.

More than 585 medical doctors have been placed through this program since its inception shortly after World War II.

The Physician Recruitment Program maintains an up-to-date listing of some 125 "open" areas needing physicians.

This service accepts requests from both physicians and communities for satisfactory placement. In addition, physicians are referred to the service by a number of organizations, among them the American Medical Association, the Illinois Department of Public Health and the Illinois Agricultural Association. Frequently, responsible citizens or overburdened physicians in a community will contact

the service.

Another important function of the Physician Recruitment Program is to assist small communities in developing programs to attract physicians such as the Doctor's Job Fair.

The Physician Recruitment Program sends a questionnaire to the applicant physician to obtain information on his educational background, his interests and preferences of type of practice. Upon return of the questionnaire, the physician is sent a complete list of openings. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities and other specifics. The physician is also sent bulletins with information on new locations as they develop.

The Physician Recruitment Program offers its assistance to all qualified physicians who request it. An applicant need not be a member of the state medical society.

### ILLINOIS MEDICAL STUDENT LOAN FUND PROGRAM

The Illinois Medical Student Loan Fund Program is designed to help those who have what it takes to become a physician, but lack sufficient financial resources or a recommendation for medical school.

Loans to students in need are provided by a joint contribution from the Illinois State Medical Society and the Illinois Agricultural Association. The program offers loans up to \$750 per semester for four years. The total amount

of loan funds available varies from year to year, depending on repayments into the revolving fund. The amount of each individual loan is determined by the student's current financial need. Loan installments are made twice a year. A low interest rate is charged semi-annually from the time the loan is received. The borrower also must insure himself for the entire amount of the loan and pay premiums on the policy. Repayment begins January 1 of the fourth

year following medical school graduation.

The program also offers assistance to those who may not have financial difficulties, but are denied matriculation into medical school because their college grades or Medical College Admission Test (MCAT) scores are marginal. The board representing the sponsoring organizations of the program can recommend candidates annually to the University of Illinois College of Medicine. After careful screening to determine whether the applicant has the potential to make a good medical student, the board can recommend him for admittance on the basis of its investigation.

In return for this assistance from the Medical Student Loan Fund Program, the applicant must agree to practice medicine in an Illinois town serving a rural population. Minimum practice time is:

(1) Freshman student receiving recommendation—five years of practice.

(2) Freshman student receiving financial assistance for four years—four years of practice.

(3) Upper classman already in medical school—one year of practice for each year that financial aid is taken (one year minimum).

The applicant may select a practice location of his own choice, provided it is in a community that has demon-

strated a physician shortage. The choice is subject to approval by the program's board. The purpose of this agreement is to provide family doctors for the rural communities of Illinois.

To be considered for assistance from the Medical Student Loan Fund Program, an applicant must be recommended by the presidents of his home county medical society and farm bureau. Rules of eligibility require that an applicant be a premedical student of at least three years college standing; that he take a medical college admissions test; and that his college grade transcript be submitted with the completed application form. Students applying to this program for a recommendation must complete an official application for admission to the University of Illinois by November 1. Illinois residency is not required.

The board of the Medical Student Loan Fund Program conducts an annual interview meeting for those students who wish to enter medical school the following September. Students qualifying for the interview are notified and invited in mid-November. Those approved for assistance are accepted on a comparative and competitive basis. Information and applications may be obtained from Roy E. Will, Secretary, Medical Student Loan Fund Board, 1701 Towanda Ave., P.O. Box 901, Bloomington, IL 61701.

## IMPARTIAL MEDICAL TESTIMONY

The Impartial Medical Testimony program, in which the Illinois State Medical Society participates, is designed to elicit objective medical truth and facilitate the equitable disposition of cases in the courts of Illinois.

As a technique of judicial administration, impartial medical testimony examiners are ordered by the court when there is evidence of a wide divergence of medical opinion in the case which is subject to litigation. The introduction of the IMT examiner and subsequent examination provides the court with objective, impartial medical data for use in pre-trial conferences and in jury trials.

Authorization for the use of IMT examiners was established by the introduction of Illinois Supreme Court Rule 17-2 (subsequently renumbered 215-d) in September, 1961.

Illinois is distinguished in this matter by being the only state which has a court rule permitting

the state-wide use of impartial medical testimony. The Illinois State Medical Society played a significant role in the creation and development of the IMT program. Impartial medical testimony in other states is limited to certain jurisdictions within the states.

The Illinois State Medical Society panel of impartial medical examiners is comprised of approximately 250 physicians who are grouped into some 20 medical specialties. Composition of the panel is reviewed annually to maintain the highest standards for the courts of Illinois.

The Illinois State Medical Society is appreciative of its role in offering, in conjunction with the Supreme Court, impartial medical service for the courts of Illinois. The IMT Committee of the state society is charged with the responsibility of maintaining the IMT panel of qualified physicians, as required by the court.

## INSURANCE PROGRAMS

### Retirement Investment Program

The Board of Trustees of the Illinois State Medical Society has approved the Retirement Investment Program which makes available to members a means of providing for retirement with group advantages that an individual physician could not otherwise obtain. The Retirement Investment Program provides for balanced investments to counter economic fluctuations.

Annuities or mutual funds alone do not meet the

problems of recession and inflation, but together they do permit a sound retirement plan.

The group annuity provides a guaranteed lifetime income at retirement, serving as a hedge against periods of recession or declining prices, while the mutual fund provides an opportunity for common stock investment serving as a hedge against periods of inflation or rising prices.

A member physician wishing this type of retirement protection may obtain it through the Illinois

State Medical Society. By doing so, he not only receives advantages he would not otherwise have, but he is able to benefit from the collective opinions and research facilities of the insurance company and the mutual fund's investment advisor.

The Retirement Investment Program, making available the group annuity at a substantial reduction in premium, and the mutual funds, is one of the most recent of its kind. This program was developed after several years of study taking into consideration other group plans and retirement alternatives.

The size of the retirement contribution, the proportion of investment between the group annuity and the mutual fund, and the retirement age are determined by the participating physician.

### Mutual Fund

The open end mutual fund consisting primarily of common stocks is Massachusetts Investors Growth Stock Fund Inc. The assets of the fund are over one billion dollars. Its' sister fund, Massachusetts Investors Trust, is the nation's oldest mutual fund. The Growth Fund is offered with an 8½% sales charge and the Investment Adviser, Massachusetts Financial Services Inc., receives an investment advisory fee of .09% per annum. The fund is quoted daily in most major newspapers including the *Wall Street Journal*.

### Tax-Qualified Retirement Program

As mentioned above, the Board of Trustees has also approved the Society's Tax-Qualified Retirement Program, which utilizes a Continental Assurance Company Group Annuity and the Massachusetts Investors Growth Stock Fund. This program is intended for members who may find the provisions of the Keogh Act to their advantage as it allows contributions made by self-employed physicians to be fully deductible. As recently revised by the Congress of the United States, the principal provisions of the Keogh Act are as follows:

1. A self-employed physician may set aside 15% of his net income from the practice of medicine or \$2,500.00 which ever is the lesser, each year for his own retirement.
2. A self-employed physician may deduct all of this amount from his income tax.
3. A self-employed physician must include all full-time employees with three or more years service under the Plan. A full-time employee is defined as an employee working twenty hours or more a week for a period of five or more months. The employee's contributions are made by the physician as a percent of salary at least equal to that percentage of net income put aside by the physician for his own retirement.
4. Funds invested under the Tax-Qualified Retirement Program accumulate tax free until distribution.

National Boulevard Bank of Chicago acts as Trustee for the Program's Annuity and Stock Fund shares and receives all physician's contributions and maintains the Program's records.

Members who are incorporated, or are considering incorporation, may wish to receive the information pertaining to the Illinois State Medical Society IRS

approved Corporate Pension and Profit Sharing Plans. This information, together with the information pertaining to the ISMS Retirement Investment Program or the Keogh Act Program, may be obtained by writing the Plan Administrator: Robinson Inc., Administrator, ISMS Retirement Programs, 209 South LaSalle Street, Chicago 60604.

### Hospital Income Plan

The Hospital Benefit Plan, approved by the Board of Trustees March 14, 1971, is available exclusively as a benefit to ISMS members. The society derives no income from sponsorship.

The Plan pays \$25 in cash (Plan A) or \$50 in cash (Plan B) for each day the participant is confined to a hospital because of accident or illness for as long as one full year, up to \$9,125 (Plan A) or \$18,250 (Plan B) for each accident or sickness.

All active members of the society, their employees and their families are eligible for participation during enrollment periods conducted by the Administrator, Robinson-Kirke Administrative Services, Inc., 209 S. LaSalle St., Chicago 60604.

The daily benefits are automatically doubled for all participants under age 65 for hospital confinement due to cancer or hospital confinement in an intensive care unit.

The plan pays regardless of any other insurance policies members have, and in addition to Medicare and Social Security benefits. Benefits are paid directly to the participant and not to a doctor or hospital. Benefits are not taxable and, therefore need not be included in one's tax return.

The coverage is limited to sickness which commences or accidents which occur while the insurance is in force. However, conditions pre-existing the effective date of insurance will be covered if the participant has not received treatment or medical advice during any period of 12 consecutive months ending after the effective date of insurance. After two years from the effective date of insurance, coverage is guaranteed regardless of any pre-existing conditions.

The plan includes these exclusions: war or act of war, service in the armed forces of any country or international authority at war, pregnancy (including childbirth or resulting complications), or intentionally self inflicted injuries, suicide or attempted suicide, whether sane or insane.

In summary, in 1971 the Hospital Benefit Plan was made available to the membership and was received very well. During enrollment periods all members regardless of age could participate. Enrollment periods are anticipated every 12 to 18 months.

### Group Disability Program

The Illinois State Medical Society's officially approved Group Disability Program is available to all eligible members of ISMS up to age 60 who are regularly attending all of the usual duties of their occupation and is renewable to age 70. Three different types of coverage are available under the program, with an over-70 conversion privilege.

Benefits of the program are payable regardless of any other insurance and no restrictive riders may be attached after issuance. The master contract contains a special renewal condition whereby the individual coverage cannot be terminated.

The program is explained in detail in a brochure which is available by writing to Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60076.

### **Group Major Medical Expense Plan**

A \$25,000 Group Major Medical Expense Plan designed for the Illinois State Medical Society has a 20% co-insurance feature and a \$500 or \$1,000 deductible, whichever the physician selects. For hospital room and board, the Plan will pay up to \$100 a day and in addition up to \$150 a day in an intensive care unit. It will pay \$20 a day in a convalescent home following release from a hospital up to 90 days. The Plan also provides maximum coverage for the insured in the event of mental illness and up to \$2,000 for dependents. It will also cover a congenital abnormality from the first day of birth after the effective date of the contract up to \$2,000.

New members joining ISMS will be allowed to enroll without evidence of insurability or health statement under age 40 within six months after notification of the Plan's availability.

The Group Major Medical Expense Plan is outstanding and will provide members with protection against catastrophic illness.

The Plan is underwritten by the Commercial Insurance Co. of Newark, N.J., and is administered by Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60076. Additional information may be obtained from the Illinois State Medical Society headquarters.

### **Professional Liability Program**

A new professional liability insurance program became available to members of the Illinois State Medical Society June 1, 1973. Underwritten by the Hartford Insurance Group and administered by Johnson and Higgins, Inc., the program requires the active involvement of physicians in claims and underwriting procedures. Through medical review committees operating in each ISMS district, the insurance company receives recommendations on the best course of action to be taken to protect the program and still be responsive to the individual physician's needs.

The program covers physicians and surgeons for alleged malpractice claims arising from professional acts or omissions. Limits of \$1 million, \$2 million, \$5 million or \$100,000/\$300,000 are available. Corporations and partnerships may be covered for an additional premium if each member is insured for a minimum of \$1 million.

Optional personal excess liability protection is also available.

More than 4,000 Illinois doctors are now enrolled in this program and new applications are being received daily at ISMS headquarters. The plan offers these unique features not obtainable elsewhere:

\*ISMS members are insured regardless of their specialty, age, experience, location or where they received their medical degrees.

### **Personal Life Insurance Program**

A guaranteed renewable term life insurance program, recommended by the Insurance Committee and approved by the Board of Trustees in 1972, is available to ISMS members in amounts ranging from \$10,000 to \$200,000. Features of the program include guaranteed future purchase options, guar-

### **Business Overhead Expense Group Plan**

Today, more than ever, maintaining a medical office is costly when one considers the increasing cost of rent, employee's salaries, accountant services, utilities, etc. The sole purpose of the Business Overhead Expense Group Plan is to step in and take care of overhead expenses during a period when the physician is totally disabled as a result of an accident or illness. In the event of a serious accident or illness, the physician can keep his office open and retain his personnel with the expenses being taken care of by the Business Overhead Expense Group Plan. This Program is not to be confused with the Group Disability Plan which provides an earned income for physician to meet his personal obligations for the maintenance of his home and family.

Monthly benefits are available up to \$2500.00 with attractive premiums. Benefits commence on the first day provided total disability lasts one (1) month or longer. It will continue while totally disabled for as long as 24 months for any one accident or period of sickness. The premiums for this particular type of coverage constitute business expenses and are deductible under Internal Revenue Service Ruling (55-264, I.R.S. 1955-19, p. 8.).

Further information may be obtained from the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie, Ill. 60076.

### **Professional Liability Program**

\*A network of volunteer medical review committees composed of ISMS members helps obtain coverage for many physicians who otherwise are unable to obtain it or must pay prohibitive premiums.

\*If a review committee rules that a physician involved in litigation—even if he loses the case or settles out of court—was practicing according to reasonable standards of care, the Hartford will not cancel his coverage or impose a deductible or surcharge.

\*The emergency claim experience of ISMS members monitored through the Johnson and Higgins computer enables the Hartford to adjust territorial and specialty rate classifications to reflect the actual experience of the ISMS group rather than the national or industrial averages.

\*ISMS members are assured of a premium structure that is competitive with other programs offered in Illinois.

\*The permanence of the program is guaranteed by a progressive enrollment requirement that is currently ahead of schedule and by a contractual provision allowing limited rate increases for the underwriter.

To facilitate premium payments, a standard quarterly billing cycle has been established.

Full details and application forms may be obtained from ISMS or Johnson & Higgins, 101 S. Wacker Dr., Chicago 60604; phone 312-236-3491.

anteed conversion privilege up to age 70, optional family insurance benefits, double indemnity and disability waiver premium.

For applications and further details, contact the administrator: A. W. Ormiston & Co., 175 W. Jackson Blvd., Chicago 60604; phone 312-922-3952.

# Ancillary Organizations

## Woman's Auxiliary To The Illinois State Medical Society

We are revising our Bylaws extensively this year in an attempt to modernize our organization and streamline its operation. Standing rules are also being developed in an attempt to provide more flexibility to our procedures of operation.

Seven District Meetings will be held, primarily in early fall. We hope to develop a closer rapport with our county auxiliaries and extend our program development.

Developing leadership on both the state and county levels is a prime objective of our Auxiliary Board. We hope to achieve this through better and more effective communication. Publication of the "Pulse" quarterly has been a marvelous aid to better communication, since all members receive it. We are most grateful to ISMS for their subsidy of "Pulse."

Immunization Action Month (October) is a project we have undertaken at the request of ISMS and the Illinois Public Health Department. Our involvement is a natural out-growth of our Health Education Symposium last

February, held jointly with ISMS. All Auxilians are urged to participate in the "Walk In" for IAM by taking posters and pamphlets to the physicians' offices. Our commitment is to help the physicians practice good preventive medicine in Illinois.

Great emphasis is placed on legislation this year. We hope to better communicate the physicians' legislative concerns to our membership. We also hope to improve our IMPAC memberships.

Auxiliary membership—its growth and maintenance—is a prime objective of our Auxiliary for this year. We hope to promote better friendships and understanding among everyone in our "medical community."

The theme for this year is HAPPINESS IS . . . and "assisting our Doctor husbands" is our goal. It is our hope that ISMS physicians will think—"Happiness is . . . their Auxiliary."

*Mrs. Thomas (Mickey) Glatter  
President*

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# **American Association Illinois of Medical Assistants Society**

Membership in the Illinois Society, American Association of Medical Assistants is open to all persons employed by physicians in administrative and clinical categories. Membership includes nurses, technicians, secretaries, bookkeepers, clerks and aides. The Society's objectives are to: (a) maintain and advance the standards of professional employment and to give honest, loyal and efficient service to the medical profession and the public; (b) assist the physicians in improving medical public relations; (c) bring into one association all medical assistant organizations of the state of Illinois; (d) provide an organization for those residing in Illinois counties where no medical assistant societies are organized; and (e) meet occasionally for interchange of ideas.

Medical Assistants join together to form component county chapters of Illinois Society, AAMA; there are active chapters in the following counties: Cook (Chicago, Aux Plaines, Southwest Suburban, and Northwest Cook), Kane, Fox Valley South (Kane), Lake, McHenry, Kankakee, Vermillion, DuPage, DeKalb, Will-Grundy, Peoria, Macon, Sangamon, Williamson-Jackson-Franklin, St. Clair, Jefferson-Hamilton, Rock Island, Fulton, McLean, LaSalle, Henry-Stark, Iroquois, Morgan-Scott, McDonough, Coles-Cumberland and Shawnee.

Local county societies and the Illinois Society conduct numerous activities and programs to educate and inform members. Major program at the state level include: (1) "traveling courses" held throughout the state; (2) a

symposium each September; (3) area meetings in conjunction with the ISMS President's Tour; (4) three-day annual meeting in April; (5) publication of a newsletter, "Executive Memo", which keeps members up to date on AAMA activities; and (6) publication of a quarterly journal, *The Illini Cardinal*.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully completing the special board examination and meeting qualifying criteria of this American Association of Medical Assistants certification program. For further information of this program write to the American Association of Medical Assistants, One East Wacker Drive, Suite 1510, Chicago 60601.

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## The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

- 1) The initiation of scientific and medical research activities.
- 2) The collection, evaluation and dissemination of the results of research activities to the public.
- 3) The implementation and management of projects related to medicine for individuals, or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical

Society. It is staffed through ISMS headquarters.

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## Illinois Council on Continuing Medical Education

This Council was created by the Illinois State Medical Society, in co-operation with the state's eight medical schools, to fulfill six purposes: (a) make readily available to all Illinois physicians CME programs that will enhance patient care; (b) catalog and co-ordinate existing programs to eliminate wasteful duplication; (c) encourage development of new CME methods, techniques, and systems; (d) help identify the learning needs of Illinois physicians; (e) seek out potential CME providers and serve as liaison between producers and consumers; and (f) encourage Illinois physicians to participate in formal CME programs.

ICCME was proposed by Dr. Edward W. Cannady in his 1969 inaugural address as President of ISMS. Following careful study, the 1970 House of Delegates approved the

plan in principle. The next President, Dr. J. Ernest Breed, vigorously pursued the idea; after the 1971 House of Delegates voted initial funding, he also served as Chairman of the Organizing Committee. The Illinois Association of Osteopathic Physicians & Surgeons also offers financial support for ICCME.

ICCME was officially chartered by the state as a non-profit educational organization in May, 1972, and began operations with the appointment of its first Executive Director in September, 1972.

ICCME is unique in three respects: (1) it is the only such organization supported by a state medical society and staffed by a full-time professional educator; (2) it unites the educational resources of the Illinois State Medical

Society and the state's medical schools; and (3) independent in action, it serves *all* interests concerned with CME and thus provides a crucial channel of communication to co-ordinate the efficient use of all available resources.

#### *Current Major Activities:*

1. Sponsor an annual Congress on Continuing Medical Education, to involve all elements of the Illinois health-care system in the Council's work. The second Congress met April 18, 1974. (For a copy of the Congress Report, just write "1974 Congress Report" on your prescription blank, and mail to: ICCME, 360 N. Michigan Ave., Chicago, IL 60601.)
2. On behalf of ISMS, perform staff work for accreditation of intra-state CME.
3. Advise hospitals and other organizations on effective CME methods.
4. Organize training sessions on CME methods for Directors of Medical Education and Program Chairmen.
5. Distribute a pamphlet, *Your Personal Learning Plan*,

offering advice on how to plan your learning most effectively. Every Illinois physician—M.D. or D.O.—may receive a copy free upon request; just write "Personal Learning Plan" on your prescription form, and mail to ICCME (*see* address under I, *above*). To all others, the cost is \$1.00/copy, postpaid.

6. Maintain a map of Illinois, plus detailed data, showing distribution of physicians and health institutions pertinent to state-wide CME planning.
7. Maintain and publish a calendar of Illinois CME activities.

#### *Organization & Governance*

Members of the ISMS Executive Committee serve as legal members of the ICCME Corporation, set basic policy, and elect the Board of Directors.

The affairs, property, and business of the Council are managed by a Board of Directors comprised of: eight practicing physicians selected by the ISMS Board of Trustees; eight academic physicians, one selected by each dean of an Illinois medical or osteopathic school; plus the chairman of the ISMS Committee on CME Accreditation.

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**EXECUTIVE DIRECTOR: Leonard S. Stein, Ph.D.**

## **Illinois Foundation for Medical Care**

The Illinois Foundation for Medical Care is a physician-member, not-for-profit corporation established in July, 1971, at the request of the ISMS House of Delegates. Through the Foundation, physicians retain the prerogatives of medical determinations and have direct participation and leadership in the design, implementation and administration of various health care programs.

Since its implementation in February, 1972, the Hospital Admission and Surveillance Program (HASP), a program of the Foundation, has certified the medical necessity and length-of-stay for more than 550,000 Medicaid admissions, as of July, 1974.

The following local foundations have affiliated with the Illinois FMC: Chicago FMC, Northern Illinois FMC, Quad River FMC, Champaign County Foundation for Health

Care, the Western Illinois FMC, the FMC of Central Illinois, and the newest foundation in Illinois, the Mid-State FMC.

Three of the affiliates are administering the HASP program in their foundation areas, and two others are in the process of contract negotiations to administer HASP in their particular areas. In addition, two of the affiliates hold commercial contracts to perform HASP-type review for major industries in their areas.

Membership in IFMC is available to any licensed physician or osteopath qualified to practice medicine in all its branches. In affiliated local foundation areas, IFMC membership is contingent upon membership in the local FMC. Information can be obtained by writing IFMC, 360 North Michigan Avenue, Suite 1418, Chicago 60601.

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| *Joseph L. Bordenave, <i>Treasurer</i><br>1665 South Street, Geneva 60134                 | A. Edward Livingston<br>325 Fairway Drive, Bloomington 61701 |
| *Robert T. Fox<br>2136 Robin Crest, Glenview 60025  | Harold Paul<br>1725 West Harrison, Chicago 60612             |
| *Joseph R. O'Donnell<br>444 Park, Glen Ellyn 60137  | Willard C. Scrivner<br>6600 West Main, Belleville 62223      |
| *James W. Sutherland<br>1305 Broadway, Quincy 62301                                       | Maynard I. Shapiro<br>7531 Stony Island, Chicago 60649       |
| *Harry E. Wachter<br>1609 W. Springfield Ave., Champaign 61820                            | R. Glenn Smith<br>1221 E. State St., Rockford 61108          |
| Andrew J. Brislen<br>6060 South Drexel, Chicago 60647                                     | Frederick E. Weiss<br>15643 Lincoln, Harvey 60426            |
| Robert J. Becker<br>229 North Hammes Ave., Joliet 60435                                   | Fred Z. White<br>723 North 2nd St., Chillicothe 61523        |
| Frank J. Jirka, Jr.<br>1507 Keystone, River Forest 60305                                  | *Member of Executive Committee                               |

## Illinois Medical Political Action Committee (IMPAC)

The Illinois Medical Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their wives. It cooperates with others in the healing arts professions. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his wife can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Con-

gress. It cooperates, both in election efforts and in membership solicitation activities, with the American Medical Political Action Committee (AMPAC), its counterpart on the national level.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Suite 2010, 360 N. Michigan Ave., Chicago 60601.

## Medical and Paramedical Education

### MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

|   |  |
|---|--|
| Chicago Medical School<br>2020 W. Ogden Ave., Chicago, 60612                            | Peoria School of Medicine, Peoria  |
| Northwestern University Medical School<br>303 E. Chicago Ave., Chicago, 60611           | Rockford School of Medicine, Rockford  |
| University of Chicago-Pritzker School of Medicine<br>950 E. 59th Street, Chicago, 60637 | School of Associated Medical Sciences, Chicago   |
| University of Illinois College of Medicine<br>1853 W. Polk Street, Chicago, 60680       | School of Basic Medical Sciences, Chicago  |
| Abraham Lincoln School of Medicine, Chicago   | School of Basic Medical Sciences, Urbana   |
| Metropolitan Hospital Group, Chicago  | Loyola University, Stritch School of Medicine<br>2160 S. First Ave., Maywood, 60153            |
|   | Rush Medical College<br>1725 W. Harrison St., Chicago 60612                                    |
|   | Southern Illinois University Medical School<br>901 N. First St., P.O. 3926, Springfield, 62708 |

## PARAMEDICAL EDUCATION

### APPROVED EDUCATIONAL PROGRAMS FOR CERTIFIED LABORATORY ASSISTANT

CHICAGO—Swedish Covenant Hospital  
V. A. West Side Hospital  
DANVILLE—St. Elizabeth Hospital  
ELGIN—Sherman Hospital  
OLNEY—Richland Memorial Hospital  
QUINCY—Blessing Hospital  
RIVER GROVE—Triton College

### APPROVED EDUCATIONAL PROGRAMS FOR CYTOTECHNOLOGIST

CHICAGO—Michael Reese Hospital & Medical Center  
University of Chicago  
University of Health Science/Chicago  
Medical School

### APPROVED EDUCATIONAL PROGRAMS FOR HISTOLOGIC TECHNICIAN

CHICAGO—St. Joseph Hospital  
University of Chicago Hospital & Clinics  
Mercy Hospital & Medical Center  
Mount Sinai Hospital & Medical Center

### APPROVED EDUCATIONAL PROGRAMS FOR MEDICAL ASSISTANTS

BELLEVILLE—Belleville Area College  
CHICAGO—Franklin School of Science & Arts

### APPROVED EDUCATIONAL PROGRAMS FOR MEDICAL LABORATORY TECHNICIAN

BELLEVILLE—Belleville Area College  
EAST PEORIA—Illinois Central College

### APPROVED EDUCATIONAL PROGRAMS FOR MEDICAL RECORD ADMINISTRATORS

CHICAGO—University of Illinois College of Medicine  
NORMAL—Illinois State University

### APPROVED EDUCATIONAL PROGRAMS FOR MEDICAL RECORD TECHNICIAN

EAST PEORIA—Illinois Central College  
PALOS HILLS—Moraine Valley Community College

### APPROVED EDUCATIONAL PROGRAMS FOR NUCLEAR MEDICINE TECHNOLOGY

CHICAGO—Northwestern Memorial Hospital  
St. Mary of Nazareth Hospital Medical Center  
EVANSTON—Evanston Hospital  
HINES—V. A. Hospital  
RIVER GROVE—Triton College

### APPROVED EDUCATIONAL PROGRAMS FOR OPERATING ROOM TECHNICIAN

MOLINE—Moline Public Hospital

### APPROVED EDUCATIONAL PROGRAMS FOR OCCUPATIONAL THERAPIST

CHICAGO—University of Illinois College of Medicine

### APPROVED EDUCATIONAL PROGRAMS FOR PHYSICAL THERAPIST

CHICAGO—Northwestern University Medical School  
University of Health Science/  
Chicago Medical School  
University of Illinois College of Medicine

### APPROVED EDUCATIONAL PROGRAMS FOR MEDICAL TECHNOLOGIST

BELLEVILLE—St. Elizabeth Hospital  
BLUE ISLAND—St. Francis Hospital  
CHAMPAIGN—Burnham City Hospital  
CHICAGO—Augustana Hospital Health Care Center  
Grant Hospital of Chicago  
Holy Cross Hospital  
Illinois Masonic Medical Center  
Louis A. Weiss Memorial Hospital  
Mercy Hospital & Medical Center  
Michael Reese Hospital & Medical Center  
Northwestern University Medical School  
Rush Medical School  
St. Anne's Hospital  
St. Anthony Hospital  
St. Joseph Hospital  
St. Mary of Nazareth Hospital  
University of Health Science/  
Chicago Medical School  
University of Illinois College of Medicine  
V. A. Research Hospital

CHICAGO HEIGHTS—St. James Hospital  
DANVILLE—Lake View Memorial Hospital  
DECATUR—Decatur Memorial Hospital  
St. Mary's Hospital  
EVANSTON—Evanston Hospital  
FREEPORT—Freeport Memorial Hospital  
GENEVA—Community Hospital  
GREAT LAKES—U.S. Naval Hospital  
HARVEY—Ingalls Memorial Hospital  
HINSDALE—Hinsdale Sanitarium & Hospital  
JOLIET—Silver Cross Hospital  
St. Joseph Hospital  
MAYWOOD—Foster G. McGaw Hosp./Loyola University  
OAK LAWN—Christ Community Hospital  
OAK PARK—West Suburban Hospital Association  
PARK RIDGE—Lutheran General Hospital  
PEORIA—Method Hospital of Central Illinois  
St. Francis Hospital  
QUINCY—St. Mary's Hospital  
ROCKFORD—Rockford Memorial Hospital  
St. Anthony Hospital  
Swedish-American Hospital  
SPRINGFIELD—St. John's Hospital  
Sangamon State University  
URBANA—Carle Foundation Hospital  
WAUKEGAN—St. Therese's Hospital  
WINFIELD—Central DuPage Hospital

## APPROVED EDUCATIONAL PROGRAMS FOR RADIOLOGIC TECHNOLOGIST

ARLINGTON HTS.—Northwest Community Hospital  
AURORA—Copley Memorial Hospital  
BELLEVILLE—Belleville Area College  
BLOOMINGTON—Bloomington Normal School X-ray  
Technology  
CENTRALIA—St. Mary's Hospital  
CHICAGO—Cook County Hospital  
DePaul University  
Edgewater Hospital  
Englewood Hospital  
Forkosh Memorial Hospital  
Franklin Boulevard Community Hospital  
Henrotin Hospital  
Illinois Masonic Medical Center  
Louis A. Weiss Memorial Hospital  
Malcolm X Community College  
Michael Reese Hospital & Medical Center  
Mount Sinai Hospital & Medical Center  
Northwestern Memorial Hospital  
Provident Hospital & Training School  
Ravenswood Hospital  
Roseland Community Hospital  
Rush University  
St. Anne's Hospital  
St. Joseph Hospital  
St. Mary of Nazareth Hospital  
South Chicago Community Hospital  
University of Illinois Hospital  
Woodlawn Hospital  
Wright Junior College  
DANVILLE—Lake View Memorial Hospital  
DECATUR—Decatur Memorial Hospital  
DIXON—Sauk Valley College  
EAST PEORIA—Illinois Central College  
ELGIN—St. Joseph Hospital  
EVANSTON—Evanston Hospital  
St. Francis Hospital  
GALESBURG—Carl Sandburg College  
GLEN ELLYN—College of DuPage  
GRAYSLAKE—College of Lake County  
HINSDALE—Hinsdale Sanitarium & Hospital  
JOLIET—St. Joseph Hospital  
KANKAKEE—Kankakee Community College

KEWANEE—Kewanee Public Hospital  
MACOMB—McDonough District Hospital  
MALTA—Kishwaukee Junior College  
MOLINE—Lutheran Hospital.; Moline Public Hospital  
MORTON GROVE—Oakton Community Hospital  
OAK PARK—West Suburban Hospital  
OLNEY—Richland Memorial Hospital  
PALOS HILLS—Moraine Valley Community College  
PEORIA—St. Francis Hospital  
QUINCY—Blessing Hospital  
St. Mary's Hospital  
RIVER GROVE—Triton College  
ROCKFORD—Rockford Memorial Hospital  
St. Anthony Hospital  
Swedish American Hospital  
ROCK ISLAND—Rock Island Franciscan Hospital  
SOUTH HOLLAND—Thornton Community College  
SPRINGFIELD—Lincoln Land Community College  
Memorial Medical Center

## APPROVED EDUCATIONAL PROGRAMS FOR RESPIRATORY THERAPIST

CHICAGO—Cook County Hospital  
Rush University  
Northwestern University Medical Center  
University of Chicago Hospitals & Clinics  
MOLINE—Lutheran Hospital  
PALOS HILLS—Moraine Valley Community College  
RIVER GROVE—Triton College  
ROCKFORD—St. Anthony Hospital  
SPRINGFIELD—Memorial Medical Center

## APPROVED EDUCATIONAL PROGRAMS FOR RADIATION THERAPY TECHNOLOGIST

CHICAGO—Rush University  
EVANSTON—Evanston Hospital  
HINES—V. A. Hospital

## APPROVED EDUCATIONAL PROGRAMS FOR SPECIALIST IN BLOOD BANK TECHNOLOGY

CHICAGO—Mount Sinai Hospital & Medical Center  
SPRINGFIELD—St. John's Hospital  
PARK RIDGE—Lutheran General Hospital

## APPROVED SCHOOLS OF NURSING

### Associate Degree Nursing Program

A coeducational nursing program under the auspices of a junior college, two years in length and leading to an Associate Degree in Nursing. The curriculum consists of arts and sciences at the junior college level and nursing theory closely coordinated with nursing practice, under direction and supervision of the college faculty, in community hospitals and health facilities.

Graduates, both men and women, are prepared to give patient-centered care in staff nurse positions in hospitals, nursing homes and similar situations. They are prepared to cooperate and to share responsibility for the patient's welfare with other members of the nursing and health staff, and to develop their own skills through experience as practicing nurses.

#### General Entrance Requirements:

Good health.  
High school graduation: with courses in biological and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units recommended).  
Qualification for admission to the college and the nursing curriculum.  
Cost: tuition in public supported junior colleges is low, in private colleges considerably higher. Add to this: fees, books, uniforms and maintenance.  
Living Arrangements: students live at home, in a college dormitory or other approved residence.  
Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").  
Belleville Area College  
Department of Nursing  
2555 W. Boulevard, Belleville 62221

|   |   |
|---|---|
| Black Hawk College<br>Department of Nursing<br>6600—34th Avenue<br>Moline 61265                           | Olive Harvey College<br>Department of Nursing<br>10001 S. Woodlawn<br>Chicago 60628   |
| College of Dupage<br>Department of Nursing<br>Lambert Rd. and 22nd<br>Glen Ellyn 60137                    | Olney Central College of Eastern Illinois<br>Department of Nursing<br>305 N. West St.<br>Olney 62450  |
| Elgin Community College<br>Department of Nursing<br>1700 Spartan Drive<br>Elgin 60120                     | Parkland College<br>Department of Nursing<br>2 Main Street<br>Champaign 61820   |
| Wm. R. Harper College<br>Department of Nursing<br>Algonquin & Roselle Road<br>Palatine 60067              | Prairie State College<br>Department of Nursing<br>157th and Halsted<br>Chicago Heights 60411  |
| Illinois Central College<br>Department of Nursing<br>Box 2400<br>E. Peoria 61611                          | Rock Valley College<br>Department of Nursing<br>Rockford 61101  |
| Joliet Community College<br>Department of Nursing<br>R.R. #3, Houbolt Avenue<br>Joliet 60436              | Carl Sandburg College<br>Department of Nursing<br>Box 1407<br>Galesburg 61401   |
| Illinois Valley College<br>Department of Nursing<br>R.R. #1<br>Oglesby 61348                              | Sauk Valley College<br>Department of Nursing<br>River Campus, R.R. #1<br>Dixon 61021  |
| Kankakee Community College<br>Department of Nursing<br>Box 888<br>Kankakee 60901                          | State Community College<br>Department of Nursing<br>417 Missouri Avenue<br>East St. Louis 62201   |
| Kaskaskia College<br>Department of Nursing<br>Shattuc Road<br>Centralia 62801                             | So. Ill. Collegiate Common Market<br>Associate Degree Nursing Program<br>908 Wall St.<br>Carbondale 62901   |
| Kennedy-King College<br>Department of Nursing<br>6800 S. Wentworth<br>Chicago 60621                       | Southwest Community College<br>Department of Nursing<br>7900 S. Pulaski<br>Chicago 60652  |
| Lake County College<br>Department of Nursing<br>19351 Washington<br>Grayslake 60030                       | Thornton Community College<br>Department of Nursing<br>50 W. 162nd St.<br>South Holland 60473   |
| Lewis & Clark Community College<br>Department of Nursing<br>Godfrey 62035                                 | Triton College<br>Department of Nursing<br>2000 5th Avenue<br>River Grove 60171   |
| Lincolnland Community College<br>Department of Nursing<br>3865 S. 6th, Frontage Road<br>Springfield 62703 | Waubonsee Community College<br>Department of Nursing<br>Rt. 47 and Harper Road<br>Box 508<br>Sugar Grove 60554  |
| Malcolm X. College<br>Department of Nursing<br>1900 W. Van Buren<br>Chicago 60612                         | <b>Baccalaureate Degree<br/>Nursing Program</b>   |
| Mayfield College Nursing Program<br>4626 N. Knox<br>Chicago 60630   | Usually a coeducational nursing program under the auspices of a college or university, this is generally four academic or calendar years in length. The curriculum combines general education with nursing education, leading to the Bachelor of Science Degree in Nursing. Liberal education courses, such as arts and sciences, are shared with all college students. University medical centers and other related hospital and community health agencies are utilized for nursing theory and practice. |
| Morraine Valley Community College<br>Department of Nursing<br>10900 S. 88th Avenue<br>Palos Hills 60465   | Graduates, both men and women, are prepared for beginning nursing positions in hospitals, nursing homes and community health services, and for advancement without further formal education to positions such as "nursing   |
| Morton College<br>Department of Nursing<br>2500 S. Austin Blvd.<br>Cicero 60650                           |   |

team" leader or head nurse. They also have the foundations for continuing personal and professional development and for graduate study and specialization in nursing.

#### General Entrance Requirements:

Good health.

High school graduation: college preparatory program including biology and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units). Two years of a foreign language may be required. Meets college or university admission standard.

Cost: college or university tuition fees for nursing programs are comparable to those for other majors. Range in Illinois is from approximately \$1,000 to \$7,000 for tuition and fees for total program. Other expenses: books, uniforms, maintenance.

Living Arrangements: students live at home, in a college dormitory or other approved residence.

Graduate is eligible to take state examination for licensure as a registered nurse ("R.N.").

<sup>†</sup> Bradley University

Department of Nursing  
Peoria 61606

Brokaw Collegiate School of Nursing  
of Illinois Wesleyan University

Bloomington 61701

Chicago State University

Department of Nursing  
95th & King Drive  
Chicago 60628

<sup>†M</sup> DePaul University

Department of Nursing  
2323 N. Seminary  
Chicago 60614

<sup>†</sup> Elmhurst College

Department of Nursing  
Elmhurst 60126

<sup>D†</sup> Lewis College

School of Nursing  
Lockport 60441

<sup>†M</sup> Loyola University

School of Nursing  
6525 N. Sheridan  
Chicago 60636

<sup>†</sup> North Park College

Department of Nursing  
5125 N. Spaulding  
Chicago 60625

<sup>†M</sup> Northern Illinois University

Department of Nursing  
DeKalb 60115

<sup>†</sup> Olivet Nazarene College

Department of Nursing  
Kankakee 60901

<sup>D†M</sup> Rush College of Nursing & Allied Health Sciences

1753 W. Congress Parkway  
Chicago 60612

<sup>†M</sup> St. Xavier College

School of Nursing  
103rd and Central Park  
Chicago 60655

<sup>†M</sup> Southern Illinois University

Division of Nursing  
Edwardsville 62025

<sup>†M</sup> University of Illinois

College of Nursing  
845 S. Damen  
Chicago 60612

#### Illinois Baccalaureate Nursing Programs For Registered Nurse Students Only

<sup>M</sup> Governors State University

College of Environmental and Allied Sciences  
Park Forest South 60466

<sup>D</sup> Sangamon State University

Department of Nursing  
Shepherd Road  
Springfield 62703

<sup>†</sup> Will admit RN students to generic baccalaureate nursing programs.

<sup>M</sup> Offers masters program(s) in nursing

<sup>D</sup> Developing

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#### Diploma (Hospital) Nursing Program

A nursing program under the auspices of a hospital or independent school of nursing, two to three years in length, and leading to a Diploma in Nursing. A college or university may provide some of the courses. The curriculum consists of theory and practice focused primarily on instruction and related clinical experience in the nursing care of patients in hospitals. Some liberal arts courses may be included.

Graduates, both men and women, have the understanding and skills necessary to organize and implement a plan of nursing that will meet the immediate needs of one or more patients and that will promote the restoration of health. They are also able to plan with associated health personnel for the care of patients, and may be responsible for the direction of other members of the nursing team.

#### General Entrance Requirements:

Good health.

High school graduation: Usually upper half of class, with courses in biological and physical sciences (1-2 units, one of which should be chemistry) and mathematics (1-2 units).

Satisfactory results on entrance tests and qualification for admission to the school.

Cost: \$900 to \$3,500; some include full maintenance.

Living Arrangements: Schools have residence facilities; many permit students to live at home if preferred.

Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

Augustana Hospital

427 Dickens

Chicago 60614

Blessing Hospital

1005 Broadway

Quincy 62301

Cook County School of Nursing

1900 W. Polk St.

Chicago 60612

Copley Memorial Hospital

Weston and Lincoln

Aurora 60507

Decatur Memorial Hospital

2300 N. Edward

Decatur 60507

Evangelical School of Nursing

4440 W. 95th St.

Oak Lawn 60453

Evanston Hospital Nursing Program

2351 W. Sherman

Evanston 60201

Franciscan Hospital  
School of Nursing  
767-30th St.  
Rockford 61201

Freeport Memorial Hospital  
1133 W. Stephenson  
Freeport 61032

Graham Hospital  
210 W. Walnut  
Canton 61520

Lutheran Hospital  
555-6th Street  
Moline 61265

Mennonite Hospital  
304 W. East Street  
Bloomington 61701

Methodist Hospital  
221 N.E. Glen Oak  
Peoria 61603

Michael Reese Hospital  
2816 S. Ellis  
Chicago 60616

Moline Public Hospital  
635 Tenth Avenue  
Moline 61265

Passavant Memorial Area Hospital  
1600 Walnut St.  
Jacksonville 62650

Ravenswood Hospital  
1931 W. Wilson  
Chicago 60640

Rockford Memorial Hospital  
2400 N. Rockton  
Rockford 61103

St. Anne's Hospital  
4950 W. Thomas  
Chicago 60651

St. Anthony Hospital  
5653 E. State  
Rockford 61101

St. Francis Hospital  
319 Ridge  
Evanston 60202

St. Francis Hospital  
211 Greenleaf  
Peoria 61609

St. John's Hospital  
401 N. 9th St.  
Springfield 62701

St. Joseph's Hospital  
333 N. Madison  
Joliet 60435

St. Mary of Nazareth  
1127 N. Oakley  
Chicago 60622

South Chicago Community Hospital  
2320 E. 93rd St.  
Chicago 60617

Swedish-American Hospital  
1316 Charles St.  
Rockford 61101

Wesley-Passavant School of Nursing  
250 E. Superior  
Chicago 60611

## Practical Nursing Program

A coeducational nursing program under the auspices of public vocational education systems hospitals or community agencies, usually one year in length. The curriculum includes nursing theory coordinated with nursing practice.

Graduates, both men and women, of programs in practical nursing are prepared for two roles: (1) under the supervision of a professional nurse or physician, they give nursing care to patients in situations relatively free of scientific complexity; (2) in a close working relationship, they assist the professional nurse in giving care to patients requiring a high degree of nursing skill and judgment.

### Entrance Requirements:

Good health.

High school: Two years minimum, graduation desirable.

Junior and senior students who are currently enrolled in high school are eligible to enroll in the practical nursing program as part of their credit curriculum. Satisfactory results on entrance tests.

References and personal interview.

Cost: None under MDTA programs, to approximately \$400 plus maintenance.

Living Arrangements: Students usually live at home or in housing approved by school.

Graduate is eligible to take the state examination for licensure as a practical nurse ("L.P.N.").

Black Hawk College  
Practical Nursing Program  
6600-34th Avenue  
Moline 61269

Bloomington School of Practical Nursing  
709 S. Clinton  
Bloomington 61701

Chicago Public Schools  
Practical Nursing Program  
1820 W. Grenshaw  
Chicago 60612

City College of Chicago  
Health Occupations Careers  
Practical Nursing Program  
721 N. LaSalle  
Chicago 60610

Danville School of Practical Nursing  
200 E. Main St.  
Danville 61832

Decatur School of Practical Nursing  
300 E. Eldorado  
Decatur 62523

East St. Louis School of Practical Nursing  
1024 N. 2nd St.  
East St. Louis 62201

F. W. Olin Vocational  
School of Practical Nursing  
2200 College Ave.  
Alton 62002

Lake County College  
Practical Nursing Program  
19351 Washington  
Grayslake 60030

Lake Land College  
Practical Nursing Program  
Mattoon 61938

Wm. Rainey Harper College  
 Practical Nursing Program  
 Algonquin & Roselle Roads  
 Palatine 60067  
 Highland College  
 Practical Nursing Program  
 511 W. Stephenson  
 Freeport 61032  
 Hinsdale Sanitarium & Hospital  
 Nursing Program  
 120 N. Oak St.  
 Hinsdale 60521  
 Illinois Central College  
 Department of Nursing  
 P.O. Box 2400  
 East Peoria 61611  
 Jacksonville Board of Education  
 Practical Nursing Program  
 504 E. Court  
 Jacksonville 62650  
 Joliet Township High School  
 Practical Nursing Program  
 201 E. Jefferson  
 Joliet 60432  
 Kankakee School of Practical Nursing  
 Kankakee Community College  
 P.O. Box 888  
 Kankakee 60901  
 Kishwaukee College  
 Practical Nursing Program  
 612 Paish  
 DeKalb 60115  
 John A. Logan College  
 Practical Nursing Program  
 Carterville 62918  
 Oakton Community College  
 Practical Nursing Program  
 7900 N. Nagle  
 Morton Grove 60053  
 Parkland College  
 Practical Nursing Program  
 2 Main Street  
 Champaign 61820  
 Quincy School of Practical Nursing  
 820 Vermont St.  
 Quincy 62301  
 Rend Lake College  
 Department of Nursing  
 315 S. Seventh  
 Ina 62846

Rockford School of Practical Nursing  
 5125-35th St.  
 Rockford 61101  
 St. Frances Cabrini  
 School of Nursing  
 811 S. Lytle  
 Chicago 60607  
 St. Mary's Hospital  
 School of Nursing  
 1015 O'Connor  
 LaSalle 61301  
 Carl Sandburg College  
 Department of Nursing  
 S. Lake Storey Rd., Box 1407  
 Galesburg 61401  
 Sauk Valley College  
 Department of Nursing  
 River Campus, Route #1  
 Dixon 61021  
 Shawnee Community College  
 Department of Nursing  
 Shawnee College Road  
 Ullin 62992  
 S. Eastern Ill. College  
 Department of Nursing  
 333 W. College St.  
 Harrisburg 62946  
 Spoon River College  
 Practical Nursing Program  
 102 E. Elm  
 Canton 61520  
 Springfield School of Practical Nursing  
 1101 S. 15th St.  
 Springfield 62704  
 Streator School of Practical Nursing  
 600 N. Jefferson  
 Streator 61364  
 Thornton Community College  
 Department of Nursing  
 50 W. 162nd St.  
 South Holland 60473  
 Triton College  
 Department of Nursing  
 2000 N. 5th Avenue  
 River Grove 60171  
 Wabash Valley College  
 Department of Nursing  
 2200 College Drive  
 Mt. Carmel 63863

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# ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 59 Legislative Districts. Each district elects one senator and three representatives. Thus, the Senate has 59 members and the House 177. Under the new constitution, senators are elected for 4 year terms, representatives are elected for 2 year terms.

The General Assembly shall convene each year on the second Wednesday of January. The General Assembly shall be a continuous body during the term for which members of the House of Repre-

sentatives are elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

## EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for

four years, beginning on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They shall be elected at the general election in 1976 and 1978 and every four years thereafter.

## LEGISLATIVE BRANCH

### Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading when it is acted upon by the entire membership of the house that is considering it.

### Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out

the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the Governor for his consideration.

If the Governor thinks the bill should become a law, he will sign it. If the Governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each House can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The Governor may also return a bill to the Legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

### Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available. Requests should be directed to: Illinois State Medical Society, Regional Office, 520 S. Sixth St., Springfield 62701.

## STATE OFFICERS

*Governor, DANIEL WALKER, Dem., Chicago  
Lieutenant Governor, NEIL F. HARTIGAN, Dem., Chicago  
Secretary of State, MICHAEL J. HOWLETT, Dem., Chicago  
Comptroller, GEORGE W. LINDBERG, Rep., Crystal Lake*

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Attorney General, WILLIAM J. SCOTT, Rep., Evanston  
Superintendent of Public Instruction, MICHAEL BAKALIS, Dem., DeKalb  
Clerk of the Supreme Court, JUSTIN TAFT, Rep., Rochester*

## **DEPARTMENT OF CHILDREN AND FAMILY SERVICES**

Room 1713, 160 N. LaSalle St., Chicago  
524 South Second St., Springfield  
Mary Lee Leahy, *Acting Director*

### **Director's Office**

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John Lambert, Deputy Director, Management Services  
Jerome Stermer, Administrative Assistant to the Director  
(Chicago)  
Steven Bishop, Administrative Assistant to the Director  
(Chicago)  
Kenneth Guza, Administrative Assistant to the Director  
(Springfield)  
Jess McDonald, Administrative Assistant to the Director  
(Springfield)  
William Ryan, Administrator, Resource Development  
Frank J. Kopecky, Administrator, Office of Legal and  
Legislative Counsel  
Sharon Garber, Ombudsman (Springfield)  
Reginald Patrick, Ombudsman (Chicago)

### **Office of Community Relations**

524 South Second Street, Springfield  
Donald H. Schlosser, *Administrator*

### **Office of Planning**

524 S. Second St., Springfield  
Neil Matlins, *Director*

### **Office of Affirmative Action**

Room 2010, 160 North LaSalle Street, Chicago  
Robert N. Thayer, *Administrator*

### **Office of Guardianship**

524 South Second Street, Springfield  
Richard S. Laymon, *Guardianship Administrator*

### **Assistant Guardians**

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Patricia Everett, 4302 North Main Street, Rockford  
William French, 1026 South Damen Avenue, Chicago  
Phillip Gorman, 1026 South Damen Avenue, Chicago  
Judy Gwin, 4500 South Sixth Street Road, Springfield  
Gracie A. Herron, 2125 South First Street, Champaign  
William King, 5415 North University, Peoria  
Margarita Martinez, 1026 South Damen Avenue,  
Chicago  
John O'Donnell, 1026 South Damen Avenue, Chicago  
William Perozzi, 310 North Tenth Street,  
East St. Louis  
David A. Sattazahn, 2209 West Main Street, Marion  
Carolyn W. Schaefer, 524 South Second Street,  
Springfield  
Fred Toole, 361 Old Indian Trail, Aurora

### **Program Services**

**Office of Education and Rehabilitation Services**  
524 South Second Street, Springfield  
Lee A. Iverson, *Director*  
Everett E. Hamilton, Funded Programs Consultant

Farrell J. Mitchell, Residential Care Consultant  
Illinois Braille and Sight Saving School  
(Jack Hartong, Supt.) Jacksonville  
Illinois Children's Hospital-School  
(Paul Kavanaugh, Supt.), 1950 West Roosevelt Rd.,  
Chicago  
Illinois School for the Deaf  
(Kenneth Mangan, Supt.), Jacksonville  
Illinois Soldiers' and Sailors' Children's School  
(Andrew Spelios, Supt.), Normal  
Illinois Veterans Home  
(Melvin Koch, Supt.), Quincy  
Illinois Visually Handicapped Institute  
(Thomas Murphy, Supt.), 1151 South Wood Street,  
Chicago  
Community Services for the Visually Handicapped  
(Peter R. Paul, Supt.), Room 1700, 160 North LaSalle  
Street, Chicago  
Evelyn Edwards Emergency Child Care Center  
(Richard Sammons, Administrator), 2020 West Roose-  
velt Road, Chicago  
Herrick House Children's Center  
(Thomas P. Brennan, Administrator), West Bartlett  
Road, Chicago  
Southern Illinois Children's Service Center  
(William F. Ayers, Administrator), Hurst  
Maryville Children's Center  
(James W. DeLeonardis, Administrator), Maryville

### **Office of Child Development**

524 South Second Street, Springfield  
Thomas E. Villiger, *Administrator*  
1439 South Michigan Avenue, Chicago  
Carlton Williams, *Assistant Administrator*

### **Program Operations**

Area Offices  
Aurora, 361 Old Indian Trail  
Champaign, 2125 South First Street  
Chicago East, 1439 South Michigan Avenue  
Chicago North, 4320 West Montrose  
Chicago South, 9718 South Halsted Street  
Chicago West, 1026 South Damen Avenue  
Decatur, 125 North Franklin Street  
East St. Louis, 310 North Tenth Street  
Joliet, 257 Springfield Avenue  
Marion, 2209 West Main Street  
Moline, 2810-41st Street  
Ottawa, 424 West Madison Street  
Peoria, 5415 North University  
Quincy, 410 North Ninth Street  
Rockford, 4302 North Main Street  
Salem, 205 East Locust Street  
Springfield, 4500 South Sixth Street Road  
Waukegan, 215 West Water Street

### **Management Services**

**Financial Management**  
524 South Second Street, Springfield  
Matthew J. Finnell, Chief

**Information Systems**  
524 South Second Street, Springfield  
Mike Timko, Chief

**Central and Field Business Management**  
524 South Second Street, Springfield  
Patricia Epperson, Acting Chief

**Office of Manpower**  
524 South Second Street, Springfield  
Thomas A. Nickell, Administrative Assistant

**Personnel Administration**  
524 South Second Street, Springfield  
John Henkhaus, Chief Personnel Officer

---

## DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

401 S. Spring St., Springfield, 62706  
160 N. La Salle St., Chicago, 60601  
LeRoy P. Levitt, M.D., Director

**Office of the Director**  
Robert E. Lanier, Special Assistant  
Jerome F. Goldberg, Chief Legal Counsel  
Meyer Proctor, Chief, Public Information Office

**Office of the Auditor**  
George M. Skadden, Chief Auditor

**Deputy Director For Management Services**  
Leonard D. Schaeffer, Deputy Director

**Division of Finance and Evaluation Services**  
Leonard D. Schaeffer, Manager

**Division of Information Services**  
Douglas Benn, Manager

**Division of Legal Services**  
Joan Matlaw, Manager

**Department of Personnel, Mental Health Field Services**  
John Meyer, Manager

**Clinical Services and Programs**  
Patrick Staunton, M.D., *Deputy Director for Clinical Services and Programs*  
James F. Griffin, Jr., *Alcoholism Program Advisor*  
Gerald Kissin, Ph.D., *Children and Adolescent Program Advisor*  
Peter Levison, Ph.D., *Research Program Advisor*  
Matthew D. Parrish, M.D., *Training Program Advisor*  
Joseph Saxl, *Accreditation Program Advisor*  
Richard Blanton, Ph.D., *Deputy Director, Developmental Disabilities*

A. L. Bowen Children's Center, A. J. Shafter, Ph.D.,  
Superintendent, Harrisburg, 62946  
Dixon State School, David Edelson, Superintendent,  
Dixon, 61021  
William W. Fox Children's Center, Myron Birkey,  
Superintendent, Dwight, 60420  
William A. Howe Development Center, Tinley Park,  
60477  
Lincoln State School, Paul Klockenga, Acting Superintendent,  
Lincoln, 62656  
Kankakee State Hospital, Ira L. Collins, Acting Superintendent,  
Kankakee, 60901  
Paul Klockenga, Acting Superintendent, Lincoln,  
62656  
Elisabeth Ludeman Mental Retardation Center, Fred  
McCormack, Superintendent, Park Forest 60466  
Warren G. Murray Children's Center, Walter Plassman, M.D., Superintendent, Centralia

Waukegan Developmental Center, P. L. Saunders,  
Superintendent, Waukegan, 60085  
Lester H. Rudy, M.D., *Group Administrator, Illinois Mental Health Institutes*

Illinois State Pediatric Institute, Herbert J. Grossman,  
M.D., Director, 1640 West Roosevelt Road, Chicago  
60608  
Illinois State Psychiatric Institute, Lester H. Rudy,  
M.D., Director, 1601 West Taylor Street, Chicago 60612  
Institute for Juvenile Research, Frank T. Rafferty,  
M.D., Director, 907 Wolcott Street, Chicago 60612  
Edward C. Senay, M.D., *Administrator, Illinois Drug Abuse Program*

### Regions and Institutions

1A (ROCKFORD): Donald W. Hart, Administrator, H.  
Douglas Singer Zone Center, 4402 N. Main St.,  
Rockford 61103

H. DOUGLAS SINGER ZONE CENTER: William G.  
Smith, M.D., Superintendent, Rockford 61103

1B (PEORIA): James Ward, M.D., Administrator,  
George A. Zeller Zone Center, 5407 N. University,  
Peoria 61614

GEORGE A. ZELLER ZONE CENTER, James Ward,  
M.D., Superintendent, Peoria 61614

EAST MOLINE STATE HOSPITAL: Konstantin Dimitri,  
M.D., Superintendent, East Moline 61244

GALESBURG STATE RESEARCH HOSPITAL: Angelo Zocchi, M.D., Acting Superintendent, Galesburg  
61401

2 (CHICAGO): Prakash N. Desai, M.D., Administrator,  
160 North LaSalle Street, Chicago, 60601

CHICAGO-READ MENTAL HEALTH CENTER:  
Peter T. Diamond, Ph.D., Superintendent, 6500 W.  
Irving Park Rd., Chicago 60634

JOHN J. MADDEN MENTAL HEALTH CENTER:  
Robert DeVito, M.D., Superintendent, 1200 S. First Ave., Hines 60141

ELGIN STATE HOSPITAL: Robert J. Mackie, M.D.,  
Superintendent, Elgin 60120

MANTENO STATE HOSPITAL: John R. Collier, Su-  
perintendent, Manteno 60950

TINLEY PARK MENTAL HEALTH CENTER: H.  
C. Piepenbrink, Superintendent, Tinley Park 60477

3A (SPRINGFIELD): William H. Anderson, M.D., Admin-  
istrator, Andrew McFarland Zone Center, 901 South-  
wind Road, Springfield 62703

ANDREW McFARLAND ZONE CENTER: Martin Cohen, Ph.D., Superintendent, Springfield 62703

JACKSONVILLE STATE HOSPITAL: William K. Murphy, Superintendent, Jacksonville 62650

<sup>3B</sup> (DECATUR-CHAMPAIGN): Walter Kemper, M.D., Administrator, Adolf Meyer Zone Center, 2310 East Mound Road, Decatur 62526

ADOLF MEYER ZONE CENTER, Dale Kelton, Ph.D., Acting Superintendent, 2310 East Mound Road, Decatur 62526

HERMAN M. ADLER ZONE CENTER (Children); J. Gregory Langan, Ed.D., Superintendent, 2204 Griffith Dr., Champaign 61820

<sup>4</sup> (EAST ST. LOUIS): Ivan Pavkovic, M.D., Administrator, Alton State Hospital, 4500 College Ave., Alton 62002

ALTON STATE HOSPITAL: Endré Komlos, M.D., Medical Director; Jos. Gruber, Admin. Director, Alton 62002

CHESTER MENTAL HEALTH CENTER, Terry B. Brelje, Ph.D., Superintendent, Chester 62233

<sup>5</sup> (CARBONDALE): Robert C. Steck, M.D., Administrator, Anna State Hospital, Anna 62906

ILLINOIS MENTAL HEALTH INSTITUTES: Lester H. Rudy, M.D., Administrator, 1601 W. Taylor St., Chicago 60612

INSTITUTE FOR JUVENILE RESEARCH: Frank T. Rafferty, M.D., Director, 907 S. Wolcott St., Chicago 60612

ILLINOIS STATE PEDIATRIC INSTITUTE: Herbert J. Grossman, M.D., Director, 1640 West Roosevelt Road, Chicago 60608

ILLINOIS STATE PSYCHIATRIC INSTITUTE: Lester H. Rudy, M.D., Director, 1601 W. Taylor St., Chicago 60612

## STATUTORY BOARDS AND COUNCILS

### 1. Mental Health Commission

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Honorable Frank M. Ozinga, Evergreen Park, Executive Secretary  
Honorable John L. Lauer, Broadwell  
Honorable E. J. "Zeke" Giorgi, Rockford  
Honorable Ben Polk, Moline  
Sanford I. Finkel, M.D., Chicago  
Elizabeth Jacob, Chicago  
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Judith S. Schild, CSW, ACSW (Chairman, Council of Professional Societies), Chicago  
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### 5. Advisory Council —PL 88-164—Construction Grants

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E. D. Stoetzel, Washington  
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Mrs. Elbert Tourangeau, Hinsdale  
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## NON-STATUTORY COUNCIL AND COMMITTEE

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Nelson Bradley, M.D., Park Ridge  
Msgr. Ignatius McDermott, Chicago  
Richard M. Sanders, Ph.D., Carbondale  
Noland B. Jones, Springfield  
James H. Oughton, Jr., Dwight  
Lewis Presnall, Long Grove  
Stephen J. Foxx, Chicago  
Paul B. Musgrove, Peoria  
Allyn Sielaff, Chicago  
William Thomas, Jr., M.D., Chicago  
Joyce C. Lashof, M.D., Springfield  
Walter H. Gregg, Ph.D., Evanston  
William W. Alderman, Chicago  
Roger Poppen, Ph.D., Carbondale  
H. Alexander Aguiar, Ph.D., Chicago  
Honorable Brian B. Duff, Chicago  
Paul Martin, Chicago  
Joel Edelman, Springfield

Phyllis K. Snyder, Chicago  
W. David Steed, M.D., S.C., Oak Park  
Joseph F. Whiteyes, Chicago

### 2. Citizens' Advisory Council for Community Services

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Hal Norris, Rockford  
Phil Karlson, Peoria  
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Bernard B. Brody, Esq., Chicago  
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Harvey W. Johnson, Jr., Springfield  
Joyce Lashof, M.D., Chicago

David M. Law, Washington  
Mary Lee Leahy, Springfield  
Allyn R. Sielaff, Chicago  
James L. Trainor, Chicago  
Eugene P. Turner, Chicago

### Dangerous Drugs Advisory Council *(Presently being developed)*

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## DEPARTMENT OF PUBLIC AID

222 South College St., Springfield  
James Trainor, *Acting Director*

The Illinois Department of Public Aid administers the federally aided public assistance programs: Aid to Families with Dependent Children; Medical Assistance; and provides supplemental financial grants to eligible recipients of the new federal Supplemental Security Income program for needy aged, blind, or disabled persons. In addition, the department allocates state funds to qualified and requesting governmental units for the administration of General Assistance; and in cooperation with the U.S. Department of Agriculture, administers the Food Stamp program.

### Administrative Staff

James M. Brown, *Senior Deputy Director*  
Jesse B. Harris, *Deputy Director—Programs and Operations*  
Bureaus:  
Income Maintenance, Robert A. Hamrick, Chief  
Social Services, Jesse B. Harris, Acting Chief

Resources and Support, Arthur C. Zimmerman, Chief  
Program Planning, Mary Ann Langston, Acting Chief  
Staff Development, William M. Fishback, Chief  
Self Support Services, Margaret J. Washnitzer, Chief  
Food Stamps, Donald Coates, Chief

Norman L. Ryan, *Deputy Director—Finance*  
Bureaus:  
Personnel Services, Joseph L. Ekiss, Chief  
Investigation, Frank M. Los, Chief  
Quality Control, Wayne H. Hamburger, Chief  
Fiscal Management, Barbara Stitcher, Chief  
Research and Statistics, Wayne D. Epperson, Chief  
Administrative Services, Floyd A. Bowman, Chief  
Robert G. Wessel, *Deputy Director—Medical Services and Information Systems*  
Bureaus:  
Medical Services, Patrick Kain, Chief  
Electronic Data Processing, Gary Paddick, Chief  
Group Care Services, Hugh L. Canaday, Chief  
Community Relations—Jose Baez, Chief

Legal Counsel and Appeals—Verne H. Evans  
Legislation—Mary-Claire Johnson and Marietta Wood  
Public Information—Barbara J. Wright  
SSI—Jesse B. Harris  
Affirmative Action Officer—James A. Johnson  
Cook County Department of Public Aid—David L. Daniel,  
Director

## Regional Offices

|                       |   |
|-----------------------|---|
| Region 1A—Rockford    | Mr. John A. Dotzel<br>Regional Director                 |
| Region 1B—Peoria      | Mr. Walter Bradbury<br>Regional Director                |
| Region 2—Elgin        | Mr. Robert A. Hamrick,<br>(Acting)<br>Regional Director |
| Region 3A—Springfield | Mr. Charles H. Pfotenhauer<br>Regional Director         |
| Region 3B—Champaign   | Mr. Ora M. Wilson<br>Regional Director                  |
| Region 4—Belleville   | Leona Franklin<br>Regional Director                     |
| Region 5—Marion       | Lawrence E. Duff<br>Regional Director                   |

## Legislative Advisory Committee on Public Aid

Sen. Don A. Moore, Midlothian, *Chairman*  
Sen. Fred J. Smith, Chicago, *Vice-Chairman*  
Joel Edelman, Crete, *Executive Director*  
John W. Carroll, Park Ridge, *Executive Secretary*  
Sen. A. C. Bartulis, Benld  
Rep. Roscoe D. Cunningham, Lawrenceville  
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Rep. Robert E. Mann, Chicago  
Sen. John B. Roe, Rochelle  
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## Medical Care Advisory Committee

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F. Paul LaFata, M.D., Springfield  
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Jacob E. Reisch, M.D., Springfield  
Alphonso L. Robinson, M.D., Mounds  
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## State Drug Advisory Committee

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Louis Gdalman, R.Ph., Chicago  
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Roy B. Maher, R.Ph., Springfield  
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Bruno W. Kwapis, D.D.S., Belleville  
D. J. McCullough, D.D.S., Wayne City  
H. B. Riley, D.D.S., Newton  
William J. Rogers, D.D.S., Chicago  
Carl L. Sebelius, D.D.S., Springfield  
Harold H. Sitron, D.D.S., Chicago

## State Advisory Committee on Group Care Facilities

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Joseph Bonnan, Chicago  
Taylor O. Braswell, Belleville  
Russell Bryant, Springfield  
Bert Cohn, Okawville  
Mrs. Rachel Dodson, Herrin  
Edward Farmilant, Chicago  
William K. Ford, M.D., Rockford  
Thomas Frey, Chicago  
Markham D. Hay, Rockford  
Elmer Johnson, Joliet  
Mrs. Laverta Johnson, Chicago  
Robert E. Lanier, Springfield  
Albert Teaters, Charleston

## State Opticians Advisory Committee

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H. V. Jones, Champaign  
Louis R. Long, Springfield  
Edwin A. Moll, Chicago  
John M. Noel, O.D., East St. Louis  
Gene Schanbaum, O.D., Chicago  
George N. Schoonover, Chicago

## State Optometric Advisory Committee

E. D. Attaya, O.D., Chicago  
Albert A. Bucar, O.D., Antioch  
Richard G. Bursua, O.D., Marion  
Thomas E. Desmond, O.D., E. St. Louis  
Albert J. Freedman, O.D., Rockford  
Henry J. Luckhardt, O.D., Westmont  
J. B. Stafford, O.D., Peoria

## State Podiatry Advisory Committee

John T. Baldwin, D.P.M., Kankakee  
Fred G. Broun, D.P.M., Oak Park  
Eugene Martin, D.P.M., Schaumburg  
O. A. Mercado, D.P.M., Chicago  
Genelle B. Smith, D.P.M., Belleville  
Raymond Turnley, D.P.M., Chicago

# DEPARTMENT OF PUBLIC HEALTH

535 West Jefferson St., Springfield 62706  
Joyce C. Lashof, M.D., Director

Robert S. Gleason, Legal Advisor  
David Bogard, Legislative Liaison

## Office of Management Services

Associate Director  
Isabelle Crawford  
Executive Assistant  
E. L. Wittenborn  
Affirmative Action & Voluntary Resource  
Dorothy Friedman  
Budget and Fiscal Operation  
Walter DeWeese  
Education and Information of Vital Records  
Stan Miles  
Electronic Data Processing  
Thomas Stuckey  
General Services  
Joseph Schweska  
Management Audit  
Al Marshall  
Public Health Laboratories  
Richard A. Morrissey  
State Center For Health Statistics  
John Napier

## Office of Consumer Health Protection

Associate Director  
Verdun Randolph  
Assistant State Sanitary Engineer  
Leroy Stratton  
Food and Drugs  
Dr. Roy Upham  
General Sanitation  
Robert Wheatley  
Milk Control  
Harold McAvoy  
Radiological Health  
Philip Brunner  
Swimming Pools and Recreation  
Jerry Ackerman  
Audit Services Rate Review  
James Handy  
Research & Development  
Ramsey Badie

## Office of Health Facilities and Quality of Care

Associate Director  
Michael A. Werckle, M.D.  
Executive Assistant  
James Yuill  
Blood Labeling—Banking  
Margaret Clune  
Hemophilia Program  
Frank Moore  
Administration  
Paul X. Elbow  
Federal Program Section  
Douglas Wade  
Hospital and Laboratory Sec.  
Robert Bilstein  
Long Term Care Section  
Donald B. St. John

Planning and Construction Sec.  
Aden H. Clump  
Rehabilitation Section  
Jan Chermak

## Office of Health Finance and Local Health

Associate Director  
Lowell Johnson

## Office of Health Services and Local Health

Associate Director  
*Vacant*  
Executive Assistant  
Shirley Reed  
Dental Health  
Carl Sebelius, D.D.S.,  
Disease Control and Communicable Disease  
Byron J. Francis, M.D.  
Poison Control  
Delores Enrietto  
Renal Dialysis  
Ruth Shriner  
Tuberculosis Control  
Al Grant  
Venereal Disease Control  
Robert Griffin  
Veterinary Medicine  
Russell Martin, D.V.M.  
Family Health  
James P. Paulissen, M.D.  
Maternal & Child Care  
James P. Paulissen, M.D.  
MEDICHEK  
Wesley J. Duiker  
WIC  
Patricia Fitzgerald  
Vision and Hearing  
Phil Shattuck  
Emergency Medical Services and Highway Safety  
*Vacant*

## Regional Offices

Region 1A 4302 North Main Street, Rockford 61103  
Region 1B 5415 North University Ave., Peoria 61614  
Region 2A 421 North County Farm Rd., Wheaton 60187  
Region 3A 4500 South 6th St. Rd., Springfield 62706  
Region 3B 2125 South 1st St., Champaign 61820  
Region 4 Cottonwood Road, R.R. 4, Edwardsville 62025  
Region 5 Rt. 3—2209 W. Main, Marion 62959

## Public Health Laboratories

2121 West Taylor, Chicago, 60612  
134 North 9th Street, Springfield 62706  
P.O. Box 2467, Carbondale 62901

## Public Health Hospitals

1919 West Taylor, Chicago, 60612  
601 North 18th St., Mt. Vernon 62864

## LOCAL HEALTH DEPARTMENTS

ADAMS COUNTY HEALTH DEPARTMENT  
Gene Mann, M.P.H., Public Health Administrator,  
333 North Sixth Street, Quincy, 62301

\*BOND COUNTY HEALTH DEPARTMENT  
Carole Bone, R.N., Acting Administrator  
107 W. College, Greenville, 62246

\*CALHOUN COUNTY HEALTH DEPARTMENT  
Mrs. Margaret Hillen, R.N., Acting Administrator  
Hardin, 62047

\*CHRISTIAN COUNTY HEALTH DEPARTMENT  
Clara J. Beaty, R.N., Acting Administrator  
Court House, Taylorville, 62568

**\*CLAY COUNTY HEALTH DEPARTMENT**

Mrs. Patricia L. Borah, R.N., Acting Administrator  
104½ West Second Street, Flora, 62839

**COOK COUNTY DEPARTMENT OF PUBLIC HEALTH**

John B. Hall, M.D., M.P.H., Director  
1425 South Racine Avenue, Chicago, 60608

**District Offices:**

North—DesPlaines  
South—Harvey  
Southwest—Oak Lawn  
West—Melrose Park

**\*DEKALB COUNTY HEALTH DEPARTMENT**

Richard B. Morgan, D.V.M., Public Health Administrator  
1731 Sycamore Road, DeKalb, 60115

**DEWITT-PIATT BI-COUNTY HEALTH DEPARTMENT**

Ruth Gregor, R.N., Acting Administrator  
122 East Main Street, Clinton, 61727

**Piatt County Office:**

Court House, Monticello 61856

**\*DOUGLAS COUNTY HEALTH DEPARTMENT**

Mrs. Evelyn Henderson, R.N., Acting Administrator  
County Court House, Tuscola, 61953

**DUPAGE COUNTY HEALTH DEPARTMENT**

Charles A. Lang, M.D., M.P.H., Health Officer  
111 N. County Farm Road, Wheaton, 60187

**EFFINGHAM COUNTY HEALTH DEPARTMENT**

Peter C. Supan, M.D., M.P.H., Health Officer  
407 E. Jefferson St., Effingham, 62401

**Egyptian Health Department**

Allen Kelly B.S., Public Health Administrator  
Route 45, Eldorado, 62930

**County Offices:**

White County—Carmi, 62821  
Gallatin County—Court House, Shawneetown, 62984

**FRANKLIN-WILLIAMSON BI-COUNTY HEALTH DEPARTMENT**

Charles W. Elder, D.D.S., Public Health Administrator  
217 East Broadway, Johnston City, 62951

**Franklin County Office:**

226 North Main, Benton, 62812

**FULTON COUNTY HEALTH DEPARTMENT**

A. James Masters, M.P.H., Public Health Administrator  
31 South Main Street, Canton, 61520

**\*GREENE COUNTY HEALTH DEPARTMENT**

Mrs. Barbara Cook, R.N., Acting Administrator  
229 North Fifth Street, Carrollton, 62016

**\*GRUNDY COUNTY HEALTH DEPARTMENT**

Mrs. Mary C. Reed, R.N., B.S., Public Health Admin.  
1340 Edwards Street, Morris, 60540

**\*HENRY COUNTY HEALTH DEPARTMENT**

Grace Van Vooren, R.N., Acting Administrator  
Court House Annex, Cambridge, 61238

**\*IROQUOIS COUNTY HEALTH DEPARTMENT**

Mrs. Nancy Zumwalt, R.N., Acting Administrator  
County Court House, Watseka, 60970

**JACKSON COUNTY HEALTH DEPARTMENT**

John B. Amadio, Ph.D., Public Health Administrator  
342A North Street, Murphysboro, 62966

**\*JERSEY COUNTY HEALTH DEPARTMENT**

Mrs. Nola Kramer, R.N., Acting Administrator  
301 S. Jefferson, P.O. Box 69, Jerseyville 62052

**JOAVIERS COUNTY HEALTH DEPARTMENT**

Ronald F. Neu, M.P.H., Acting Public Health Admin.  
311 South Main Street, Galena, 61036

**\*KENDALL COUNTY HEALTH DEPARTMENT**

Ruth Ann Little, R.N., Acting Administrator  
105 Fox Road, Yorkville, 60560

**LAKE COUNTY HEALTH DEPARTMENT**

Eugene Theios, M.P.H., Acting Director  
3010 Grand Avenue, Waukegan, 60085

**LAWRENCE COUNTY HEALTH DEPARTMENT**

Maxine Jackman, R.N., Public Health Administrator  
Court House, Lawrenceville, 62439

**LEE COUNTY HEALTH DEPARTMENT**

E. S. Parmenter, M.D., Health Officer  
413 E. First St., Dixon, 61021

**\*LIVINGSTON COUNTY HEALTH DEPARTMENT**

Mrs. Gladys Kohrt, R.N., Acting Administrator  
R.R. 4, Convalescent Center Building, Pontiac, 61764

**\*LOGAN COUNTY HEALTH DEPARTMENT**

Thomas A. Oas, Acting Public Health Administrator  
128 Pine Street, Lincoln, 62656

**\*MCHENRY COUNTY HEALTH DEPARTMENT**

Richard A. Wissell, M.P.H., Public Health Administrator  
2200 N. Seminary Avenue, Woodstock, 60098

**MCLEAN COUNTY HEALTH DEPARTMENT**

E. E. Diddams, M.S.P.H., Public Health Administrator  
401 West Virginia Avenue, Normal, 61761

**MACON COUNTY HEALTH DEPARTMENT**

Robert E. Shrout, M.A., Public Health Administrator  
1085 South Main Street, Decatur, 62521

**\*MENARD COUNTY HEALTH DEPARTMENT**

Acting Administrator  
809 Old Salem Road, Petersburg, 62675

**\*MONROE COUNTY HEALTH DEPARTMENT**

Mrs. Mary Kruse, R.N., Acting Administrator  
224 E. 3rd Street, Waterloo, 62298

**MONTGOMERY COUNTY HEALTH DEPARTMENT**

C. Tom Larson, B.S., M.H.A., Public Health Administrator  
200 South Main Street, Hillsboro, 62049

**MORGAN COUNTY HEALTH DEPARTMENT**

William D. Meyer, B.S., Public Health Administrator  
234½ West State Street, Jacksonville, 62650

**\*OGLE COUNTY HEALTH DEPARTMENT**

David Stevens, D.V.M., Acting Administrator  
106 South Fifth Street, Oregon, 61061

**PEORIA COUNTY HEALTH DEPARTMENT**

Harold H. Rohrer, M.D., M.P.H., Director  
2114 North Sheridan Road, Peoria, 61604

**\*PIKE COUNTY HEALTH DEPARTMENT**

Mrs. Martha Lowry, R.N., Acting Administrator  
216 North Monroe, Pittsfield, 62363

**QUADRI-COUNTY HEALTH DEPARTMENT**  
William Hensley, Acting Administrator  
Golconda, 62938

Massac County Office:  
Court House, Metropolis, 62960  
Johnson County Office:  
Vienna, 62995  
Hardin County Office:  
Gross Building, Elizabethtown, 62931

\***RANDOLPH COUNTY HEALTH DEPARTMENT**  
Mrs. Marilynn Murphy, R.N., B.A., Acting Administrator  
110 West Jackson Street, Sparta, 62286

\***ROCK ISLAND COUNTY HEALTH DEPARTMENT**  
Fred J. Siebenmann, Jr., B.S., Public Health Admin.  
2116 25 Ave., Rock Island, 61201

**SHELBY COUNTY HEALTH DEPARTMENT**  
Peter C. Supan, M.D., M.P.H., Health Officer  
123 North Broadway, Shelbyville, 62565

\***STEPHENSON COUNTY HEALTH DEPARTMENT**  
Arlo J. Anderson, B.S., Public Health Administrator  
12 North Galena Avenue, Freeport, 61032

**TAZEWELL COUNTY HEALTH DEPARTMENT**  
Gordon J. Poquette, M.P.H., Public Health Administrator  
1505 Valle Vista, Pekin, 61554

**TRI-COUNTY HEALTH DEPARTMENT**  
Ralph K. Gibson, R.P.E., Public Health Administrator  
529 Cross Street, Cairo, 62914  
Union County Office:  
Jonesboro, 62952

\***VERMILION COUNTY HEALTH DEPARTMENT**  
Public Health Administrator  
808 North Logan, Danville, 61832

\***WABASH COUNTY HEALTH DEPARTMENT**  
Mrs. Dorothy Munro, R.N., Acting Administrator  
Court House, Mt. Carmel, 62862

\***WHITESIDE COUNTY HEALTH DEPARTMENT**  
Joseph V. Sabaitis, D.V.M., Public Health Administrator  
201 West First Street, Rock Falls, 61071

\*with limited services

\*\*Organized under the *Coleman Act*

**WILL COUNTY HEALTH DEPARTMENT**  
James C. Barringer, B.S., Public Health Adm.  
501 Ella Avenue, Joliet, 60433

**WINNEBAGO COUNTY DEPARTMENT OF PUBLIC HEALTH**  
Joseph Orthofer, D.V.M., P. H. Administrator  
401 Division St., Rockford, 61108

#### Others

Berwyn Health Department  
J. V. Pelech, M.D., Health Director  
6600 West 26th Street, Berwyn, 60402

\*\*Champaign-Urbana Public Health District  
Gale Fella, M.P.H., Public Health Administrator  
505 South Fifth Street, Champaign, 61820

Chicago Board of Health  
Murray C. Brown, M.D., Commissioner of Health  
Chicago Civic Center, Room 219, Chicago, 60602

\*\*East Side Health District  
Mani K. Sashankar, M.D., Dr.P.H., Public Health Director  
638 North 20th Street, East St. Louis, 62205

Evanston-North Shore Health Department  
William J. Hixon, Acting Public Health Director  
1806 Maple Avenue, Evanston, 60201

Hygienic Institute  
Arlington Ailes, M.P.H., Public Health Admin.  
LaSalle, 61301

Oak Park Department of Public Health  
Herbert Ratner, M.D., Public Health Director  
129 Lake Street, Oak Park, 60302

Peoria Department of Health  
Harold H. Rohrer, M.D., M.P.H., Director  
2116 North Sheridan Road, Peoria, 61604

Skokie Health Department  
Samuel L. Adelman, M.D., M.P.H., Director of Health  
8031 Floral Street, Skokie, 60076

\*\*Stickney Township Public Health District  
Kenneth Rehnquist, Acting Public Health Director  
5635 State Road, Burbank, P.O. 60459

### STATUTORY BOARDS AND COMMISSIONS (Allied with Public Health Operations)

**Long-Term Care Facilities Advisory**  
Joyce C. Lashof, M.D., Springfield, *Chairman*  
C. R. White, Carbondale  
Michael N. Fleming, R.N., Franklin Grove  
Joseph D. Patton, Springfield  
Hugh Canaday, Springfield  
Miss Maryann Fischer, R.N., Peoria  
Taylor O. Braswell, M.H.S., Belleville  
Stanley Palutsis, M.D., Cicero  
John Coggeshall, Belleville  
George M. Bersted, Monmouth  
Lee Harvey, E. St. Louis  
Daniel Halpern, Highwood

Charles W. Boyer, Peoria  
Michael V. Friedlich, Columbia  
Walter G. Wright, Bloomington  
Roger Kesner, Highland  
Robert Lanier, Springfield, *ex-officio*

**Hazardous Substances Advisory Council**  
Richard C. Reinke, Lemont  
Ronald B. Mack, M.D., Berwyn  
Edward F. O'Toole, Chicago  
Warren Shore, Chicago  
Wesley E. Sharer, Chicago  
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### **Advisory Hospital Council**

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REPRESENTATIVES OF PUBLIC AGENCIES

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Robert G. Wessel, Springfield

John W. Rice, Olney

George C. Phillips, Jr., Springfield

Robert W. O'Leary, Chicago

Murray Berg, Chicago

Robert M. Magnuson, Elmhurst

Fredric D. Lake, M.D., Evanston

David S. Forkosh, M.D., Chicago

Daniel K. Bloomfield, M.D., Urbana

Andrew J. Griffin, M.D., Chicago

Francis Bihss, M.D., Belleville

Charles T. Bell, Carthage

Mrs. Louise M. Eggert, Oak Lawn

Miss Margaret Cassin, East St. Louis

Roger White, Chicago

Mrs. Nancy B. Jefferson, Chicago

Lee Pravatiner, Chicago

Hiram Sibley, Chicago

Mrs. Susan Bandlow Gende, Moline

Ms. Hilda E. Frontany, Chicago

Michael A. Lass, Evanston

### **Ambulatory Surgical Treatment Center Licensing Board**

Gwendolyn Boyd Schmidt, M.D., Chicago, *Chairman*

E. Wynn Presson, Rockford

Robert E. Bowen, M.D., Springfield

James E. Coeur, M.D., Carthage

Edward Jesse Jacobs, M.D., Arlington Heights

Robert L. Ewbank, D.D.S., Danville

Marion Etten, R.N., B.S.N., M.N.A., Chicago

James R. Cook, Ph.D., Charleston

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### **Clinical Laboratory and Blood Bank Advisory Board**

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Wayne N. Leimbach, M.D., Aurora

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### **Hospital Licensing Board**

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Sister Ann Bailey, Decatur

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### **Migrant Labor Advisory Committee**

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Naomi Hiett, Springfield

Walter S. Sass, Chicago

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Arthur Gottschalk, Flossmoor

Gary Granby, Verona

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### **Ohio River Valley Water Sanitation Commission**

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### **Radiation Protection Advisory Council**

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Seymour Yale, D.D.S., Chicago

F. E. Demaree, Chicago

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David H. Armstrong, *Ex Officio*, Springfield

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### **Illinois Chronic Renal Disease Advisory Committee**

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Franklin D. Schwartz, M.D., Chicago

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Thelma Trice, Chicago

Margaret Busgen, R.N., Springfield

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David Greeley, M.D., Chicago

Norman Frank, M.D., Clarendon Hills

Byron J. Francis, M.D., Springfield, *Technical Secretary*

James P. Paulissen, M.D., Springfield, *Staff*

Daniel J. Pachman, M.D., Chicago

### **Hearing Advisory Committee**

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Robert K. Simpson, Springfield

Raul Rittmanic, Dixon

H. L. McCarthy, Springfield

Ralph Naunton, M.D., Chicago

Noel Matkin, Evanston

John B. Hall, M.D., Chicago

J. Buckley, Gurnee

Howard T. Calvin, Pekin

William Plotkin, Chicago

El. Grossner, Springfield

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**Tuberculosis Advisory Committee**

Ben Kiningham, Springfield  
E. A. Piszczek, M.D., Chicago  
John Egeldorf, Hinsdale  
Eric Peterson, M.D., Coal Valley  
Mrs. Esther Smith, Chicago  
W. D. Tuttle, M.D., Harrisburg  
Virgil Smith, Metropolis  
H. H. Rohrer, M.D., Peoria  
Whitney Addington, M.D., Chicago

**Sickle Cell Committee**

Billie W. Adams, M.D., Chicago, *Chairman*  
Julian Berman, M.D., Chicago  
Rowine Brown, M.D., Chicago  
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Nancy Jefferson, Chicago  
Rev. Roy Neal, Chicago  
Rev. Edward Reddick, Chicago  
Joseph Semper, Chicago

**Helen Sutton, Chicago**

Florence Winfield, Chicago  
Peter Carruthers, Chicago  
Roger Grimes, Cairo  
Jesse Viers, Rock Island  
Vernell Burris, Centralia

**Recreational Area Advisory Council**

William G. Crumrin, Martinsville  
Alvin Henninger, Garden Prairie  
Robert Stroyeck, Mt. Zion  
Jerry Van Meter, Springfield  
Frank Goetschel, New Lenox  
Kenneth Condit, Washburn  
Wm. Donels, Springfield  
Michael Adsit, Springfield

**Plumbing Code Advisory Council**

Mr. Robert Ohlendorf, O'Fallon  
John R. Holt, Galesburg  
Scott Weller, III, Bloomington  
Edward F. Brabec, Chicago

**NON STATUTORY BOARDS**

(Allied with Public Health Operations)

**Committee for Revision of the Rules and Regulations for the Control of Communicable Diseases**

Byron J. Francis, M.D., Springfield, *Chairman*  
John B. Hall, M.D., Chicago  
Helen Bruening, R.N., Springfield  
Richard A. Morrissey, Chicago  
James P. Paulissen, M.D., Springfield  
Harry Harding, M.D., Evanston  
Olga Brolnitsky, M.D., Chicago  
Hugh Rohrer, M.D., Peoria  
Stuart Levin, M.D., Chicago  
Daniel F. Pachman, M.D., Chicago, *Ex Officio*

**Advisory Committee for Heritable Metabolic Diseases**

Herbert Grossman, M.D., Chicago  
John B. Hall, M.D., Chicago  
Herbert F. Philipsborn, Jr., Glencoe  
Julian Berman, M.D., Chicago  
Richard A. Morrissey, Chicago  
Daniel F. Pachman, M.D., Chicago  
Margaret O'Flynn, M.D., Chicago  
Edward F. Lis, M.D., Springfield  
Ira Rosenthal, M.D., Chicago  
James P. Paulissen, M.D., Springfield

**Technical Advisory Committee on Lasers**

Isaac D. Abella, Ph.D., Chicago  
Herman Cember, Ph.D., Evanston  
Charles L. Cheever, Argonne  
Nick Holonyak, Jr., Ph.D., Urbana  
Clifford E. Mensing, Maywood  
Frank W. Newell, M.D., Chicago

**Advisory Committee on Pediatric Lead Poisoning**

Fred Z. White, M.D., Chillicothe, *Chairman*  
A. J. Kiessel, M.D., Decatur, *Vice-Chairman*  
Fra M. Rosenthal, M.D., Chicago  
Guy A. Pandola, M.D., Joliet  
Eleanor Berman, Ph.D., Chicago  
Henrietta K. Sachs, M.D., Glencoe  
Ronald B. Mack, M.D., Berwyn

Rowine Hayes-Brown, M.D., Chicago  
Richard A. Morrissey, Chicago  
Verdun Randolph, Springfield

**Committee For Perinatal Health Planning**

Mrs. Jean Adams, Rockford  
William Albers, M.D., Peoria  
Joyce K. Bain, Rockford  
Violet Barkauskas, Chicago  
Sister Mary Bede, Murphysboro  
John J. Boehm, M.D., Chicago  
Ronald Burmeister, M.D., Rockford  
Joseph Christian, M.D., Chicago  
Jess Diamond, M.D., Springfield  
Thomas R. Eckman, M.D., Chicago  
W. Robert Elghammer, M.D., Danville  
David E. Fisher, M.D., Chicago  
Elizabeth Friedman, R.N., Urbana  
Leon P. Gardner, M.D., Joliet  
Jeffry Gauthier, Davenport, Iowa  
Dr. Paul Granoff, Aurora  
Dr. Wm. Hamilton, Carbondale  
Robert Hartman, M.D., Jacksonville  
William Larsen, M.D., Woodstock  
Peter McFarlane, M.D., Alton  
Robert Meisenheimer, M.D., Chicago  
Joseph Orthofer, D.V.M., Rockford  
James Paulissen, M.D., Springfield  
Jacelyn Schlautman, Chicago  
Herta Schrom, M.D., Springfield  
Bill Snyder, Rockford  
Gerald F. Staub, M.D., Rockford  
Wm. L. Stewart, M.D., Springfield  
Mr. Jack Taft, St. Charles  
Wm. G. Thomas, M.D., Sycamore  
Tim Miller, M.D., Peoria

**Advisory Committee on Prevention of Accidental Poisoning in Children**

Byron J. Francis, M.D., Springfield, *Chairman*  
Joseph R. Christian, M.D., Chicago  
W. L. Crawford, M.D., Rockford

J. Keller Mack, M.D., Springfield  
 Paul Pierce, M.D., Alton  
 John B. Stull, M.D., Olney  
 Walter M. Whitaker, M.D., Quincy

**Youth Camp Advisory Council**

Marvin Erdal, Lake Villa  
 Margaret Keeley, Chicago  
 Byron Smalley, Oak Brook  
 Robert Brower, Evanston  
 William B. Detrich, Hudson

**Private Sewage Disposal Code Advisory Committee**  
 Robert Humphrey, North Aurora  
 Gordon Ytell, Springfield  
 Larry Sidener, Rochester  
 Ben Boyd, Normal  
 Orville Meyer, Wheaton  
 Jim Buitt, Murphysboro

## TRAUMA CENTERS IN ILLINOIS

**REGIONAL EMERGENCY DIALING.** For accident information or reporting, call the nearest RED number in your area. This is the emergency switchboard number at the Trauma Center.

1. Indicates Center offers Emergency Medical Technician—Ambulance (EMT—A) program.
2. Indicates center offers Advanced EMT—A Paramedic program\*\*

3. Indicates center offers Trauma—Critical Nurse Education Programs.

\*\*Other EMT—A Advanced Programs offered, but not at a trauma center include: Ingalls Memorial Hospital, Harvey; Victory Memorial Hospital, Waukegan; Highland Park Hospital Foundation, Highland Park; Condell Memorial Hospital, Libertyville; St. Francis Hospital, Evanston; McHenry Medical Group, McHenry; and Mercy Hospital, Urbana.

| CITY                                  | TYPE OF TRAINING PROGRAMS AVAILABLE | HOSPITAL   | RED NUMBER   |
|---------------------------------------|-------------------------------------|--|--------------|
| ARLINGTON HEIGHTS<br>Joseph C. Halvey | 1, 2                                | Northwest Community Hospital<br>800 W. Central Road<br>Arlington Heights 60005                     | 312/259-1000 |
| AURORA                                | 1                                   | Mercy Center for Health Care Services<br>1325 No. Highland Avenue<br>Aurora 60506                  | 312/859-2222 |
| BELLEVILLE<br>John Santoro            | 1                                   | Memorial Hospital<br>4501 N. Park Drive<br>Belleville 62223  | 618/233-7750 |
| BLOOMINGTON<br>Ray Burke              | 1                                   | St. Joseph's Hospital<br>2200 E. Washington St.<br>Bloomington                                     | 309/662-3311 |
| CAIRO                                 |                                     | St. Mary's Hospital<br>2020 Cedar Street<br>Cairo 62914  | 618/734-2400 |
| CANTON<br>George Inman                | 1                                   | Graham Hospital Association<br>210 W. Walnut Street<br>Canton 61520                                | 309/647-5240 |
| CARBONDALE<br>Charles Loftis          | 1, 3                                | Doctors Memorial Hospital<br>404 W. Main Street<br>Carbondale 62901                                | 618/549-0721 |
| CHAMPAIGN<br>Dick Jones               | 1, 3                                | Burnham City Hospital<br>311 E. Stoughton St.<br>Champaign 61820                                   | 217/337-2500 |
| CHICAGO                               |                                     | Children's Memorial Hospital<br>2300 Children's Plaza<br>Chicago 60612                             | 312/649-4000 |
| Jeff Grubczak                         | 1, 3                                | Cook County Hospital<br>1825 W. Harrison<br>Chicago 60612  | 312/633-6040 |
| Wiley Hall                            | 1                                   | Northwestern University Hospital<br>Spinal Cord Injury Center<br>250 E. Superior Street<br>Chicago | 312/649-2000 |
| Jim Hodge                             | 1                                   | Michael Reese Hospital and<br>Medical Center<br>2929 So. Ellis Ave.<br>Chicago 60616               | 312/791-2000 |

| CITY             | TYPE OF<br>TRAINING<br>PROGRAMS<br>AVAILABLE | HOSPITAL   | RED NUMBER   |
|------------------|--|--|--------------|
| CHICAGO HEIGHTS  | 2  | Resurrection Hospital<br>7435 W. Talcott Ave.<br>Chicago 60631                                 | 312/774-8000 |
| James Strickland | 1  | St. James Hospital<br>1423 Chicago Road<br>Chicago Heights 60411                               | 312/756-1000 |
| DANVILLE         | 1  | St. Elizabeth Hospital<br>600 Sager Avenue<br>Danville 61832                                   | 217/442-6300 |
| Gene William     |  |  |              |
| DECATUR          | 1  | Decatur Memorial Hospital<br>2300 N. Edward Street<br>Decatur 62526                            | 217/877-8121 |
| Gil Dixon        |  |  |              |
| DEKALB           | 1  | DeKalb Public Hospital<br>680 Haish Boulevard<br>DeKalb 60115                                  | 815/758-2431 |
| EAST ST. LOUIS   | 1  | St. Mary's Hospital<br>129 North 8th Street<br>East St. Louis 62201                            | 618/274-1900 |
| Robert Nash      |  |  |              |
| EFFINGHAM        | 1  | St. Anthony Memorial Hospital<br>503 N. Maple Street<br>Effingham 62401                        | 217/342-2121 |
| Milton Ellefson  |  |  |              |
| ELGIN            | 1, 2   | Sherman Hospital Association<br>934 Center Street<br>Elgin 60120                               | 312/742-9800 |
| Terry Mullings   |  |  |              |
| ELMHURST         | 1  | Memorial Hospital of DuPage Co.<br>209 Avon Road<br>Elmhurst 60126                             | 312/437-5500 |
| John Hunt        |  |  |              |
| EVANSTON         | 1, 3   | Evanston Hospital Association<br>2650 Ridge Avenue<br>Evanston 60201                           | 312/492-2000 |
| William Lever    |  |  |              |
| FREEPORT         | 1  | Freeport Memorial Hospital<br>420 S. Harlem Avenue<br>Freeport 61032                           | 815/233-4131 |
| Leo Kukla        |  |  |              |
| GALESBURG        | 1  | St. Mary's Hospital<br>239 So. Cherry Street<br>Galesburg 61401                                | 309/343-3161 |
| Marcus Barber    |  |  |              |
| GRANITE CITY     | 1  | St. Elizabeth Hospital<br>2100 Madison Avenue<br>Granite City 62040                            | 618/876-2020 |
| Tony Marquez     |  |  |              |
| HARRISBURG       | 1  | Doctors Hospital of Harrisburg, Inc.<br>17 Country Club Court<br>Harrisburg 62946              | 618/253-7671 |
| Billy Morgan     |  |  |              |
| JACKSONVILLE     | 1  | Passavant Memorial Area<br>Hospital Association<br>1600 W. Walnut Street<br>Jacksonville 62650 | 217/245-9541 |
| Don Karcher      |  |  |              |
| JOLIET           | 1  | St. Joseph Hospital<br>333 N. Madison Street<br>Joliet 60435                                   | 815/725-7133 |
| James Strickland |  |  |              |
| KANKAKEE         | 1  | St. Mary's Hospital<br>150 South 5th Avenue<br>Kankakee 60901                                  | 815/939-4111 |
| Manuel Arive     |  |  |              |
| LA SALLE         | 1  | St. Mary's Hospital<br>1015 O'Conor Avenue<br>LaSalle 61301                                    | 815/223-0607 |
| Jim Golasich     |  |  |              |

| CITY                         | TYPE OF<br>TRAINING<br>PROGRAMS<br>AVAILABLE | HOSPITAL  | RED NUMBER   |
|------------------------------|--|---|--------------|
| LINCOLN<br>Tom Yocom         | 1  | Abraham Lincoln Memorial Hospital<br>315-8th Street<br>Lincoln 62656                                  | 217/732-2161 |
| LITCHFIELD<br>Fred Long      | 1  | St. Francis Hospital<br>706 South State Street<br>Litchfield 62056                                    | 217/324-2191 |
| MACOMB<br>George Inman       | 1  | McDonough County District Hospital<br>525 E. Grant Street<br>Macomb 61455                             | 309/833-4101 |
| MATTOON<br>Ken Gagnon        | 1  | Memorial District Hospital<br>of Coles County<br>2101 Champaign Avenue<br>Mattoon 61938               | 217/234-8881 |
| MAYWOOD<br>Don Poole         | 1, 2, 3                                      | Foster G. McGaw Hospital<br>Loyola University Medical Center<br>2160 S. First Avenue<br>Maywood 60153 | 312/531-3800 |
| MOLINE<br>Jerry Wolf         | 1  | Moline Public Hospital<br>635-10th Avenue<br>Moline 61265   | 309/762-3651 |
| Mt. VERNON<br>Meile Soule    | 1  | Good Samaritan Hospital<br>605 North 12th Street<br>Mt. Vernon 62864                                  | 618/242-4600 |
| OAK LAWN<br>James Strickland | 1  | Christ Community Hospital<br>4440 West 95th Street<br>Oak Lawn 60453                                  | 312/425-8000 |
| OLNEY<br>James Simmons       | 1  | Richland Memorial Hospital<br>800 E. Locust Street<br>Olney 62450                                     | 618/395-2131 |
| PARIS                        |  | Paris Community Hospital<br>East Court Street<br>Paris 61944  | 217/465-4141 |
| PEORIA                       | 1, 3   | St. Francis Hospital<br>530 N.E. Glen Oak Avenue<br>Peoria 61603                                      | 309/672-2000 |
| PINCKNEYVILLE                |  | Pinckneyville Community Hospital<br>101 N. Walnut Street<br>Pinckneyville 62274                       | 618/357-2187 |
| PONTIAC<br>Don Hutchings     | 1  | St. James Hospital<br>610 E. Water Street<br>Pontiac 61764  | 815/844-5134 |
| QUINCY<br>Marvin Reed        | 1  | Blessing Hospital<br>1005 Broadway<br>Quincy 62301  | 217/223-5811 |
| ROCKFORD<br>Roy Leslie       | 1  | St. Anthony Hospital<br>6666 E. State Street<br>Rockford 61101  | 815/226-2010 |
| SPRINGFIELD<br>Jim Siebert   | 1, 3   | St. John's Hospital<br>701 E. Mason Street<br>Springfield   | 217/544-6464 |
| STERLING<br>Billy Boswell    | 1  | Community General Hospital<br>1601 First Avenue<br>Sterling 61081                                     | 815/625-0400 |
| WAUKEGAN<br>Jim Hestad       | 1  | St. Therese Hospital<br>2611 W. Washington Street<br>Waukegan 60085                                   | 312/688-5800 |
| WOOD RIVER<br>Bob Miller     | 1  | Wood River Township Hospital<br>Edwardsville Road<br>Wood River 62095                                 | 618/254-3821 |

## DEPARTMENT OF REGISTRATION AND EDUCATION

628 East Adams Street, Springfield  
Ronald E. Stackler, *Director*  
John Galvin, *Coordinator*  
John B. Hayes, *Supt. of Registration*

The department is primarily concerned with the registration, licensing and enforcement of 32 laws governing the different professions, trades and occupations, including the Medical Practice Act. Enforcement of the Medical Practice Act is in the Division of Professional Supervision headed by a coordinator. Registration and licensing is under the jurisdiction of the Division of Registration.

The Medical Examining Committee appointed by the director of the department operates within the framework of the act and is charged with the responsibility of giving examinations for licensure, hearing complaints for revocation and suspension of licenses and promulgating rules and regulations for the administration of the act.

### Medical Examining Committee

Kenneth H. Schnepp, M.D., Springfield, *Chairman*  
Paul Tullio, D.C., Chicago  
Basil Chronis, M.D., Palos Heights  
Dale E. Richardson, D.O., Pontiac  
S. David Ross, M.D., Springfield  
Warren D. Tuttle, M.D., Harrisburg

### Medical Practice Act

#### LICENSING AND ENFORCEMENT PROCEDURES

Illinois statutes provide for licensing of physicians to practice medicine "(1) in all of its branches, and (2) licensing of those persons to treat human ailments without the use of drugs or medicine and without operative surgery."

The Medical Practice Act states, "no person shall practice medicine, or any of its branches, or midwifery, or any system or method of treating human ailments without the use of drugs or medicines and without operative surgery, without a valid existing license so to do." Applicant for license must pass an examination of his qualifications which must be satisfactory to the Department of Registration and Education.

This act does not prohibit the practice of medicine by a person who is licensed to practice medicine in all of its branches in any other state of the United States or the District of Columbia who has applied in writing to the Department, in form and substance satisfactory to the Department, for a license to practice medicine in all of its branches and has complied with all of the provisions of Section 13, except the passing of an examination which may be given under Section 13, until:

(a) the expiration of 6 months after the filing of such written application, or

(b) the decision of the Department that the applicant has failed to pass an examination within 6 months or failed without an approved excuse to take an examination conducted within 6 months by the Department, or

(c) the withdrawal of the application. (Added by Act approved July 26, 1971)

Any person licensed under this Act who dispenses any drug or medicine shall affix to the box, bottle, vessel or package containing the same a label indicating (a) the date on which such drug or medicine is dispensed; (b) the last name of the person dispensing such drug or medicine; (c) the directions for use thereof; and (d) the proprietary name or names or, if there is none, the established name or names of the drug or medicine, the dosage and quantity, unless the person dispensing the drug or medicine determines that the health of the person to whom the drug or medicine is dispensed requires that such information be omitted. This Section shall not apply to drugs or medicines in a package which bears a label of the manufacturer containing information describing its contents which is in compliance with requirements of the Federal Food, Drug and Cosmetic Act and the Illinois Food, Drug and Cosmetic Act and which is dispensed without consideration by a practitioner licensed under this Act. "Drug" and "medicine" have the meaning ascribed to them in the "Pharmacy Practice Act," approved July 11, 1955, as now or hereafter amended. (Added by Act approved September 24, 1971)

*Minimum standards of professional education.* Except as provided in Section 9a of this Act, the minimum standards of professional education to be enforced by the department in conducting examinations and issuing licenses shall be as follows:

1. *Practice of Medicine.* For the practice of medicine in all of its branches:

(a) For an applicant who is a graduate of a medical college before the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to graduation a 4 years' course of instruction of not less than 9 months each, in such medical college, or its equivalent, the time elapsing between the beginning of the first year and the ending of the fourth year having been not less than 40 months, and which was reputable and in good standing in the judgment of the department; and prior to taking such examination said applicant must present proof that he has completed a 4 years' course of instruction in a high school or its equivalent as determined by an

examination conducted by the department.

(b) For an applicant who is a graduate of a medical college after the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to admission thereto 2 years' course of instruction in a college of liberal arts, or its equivalent, or in such medical college, and a course of instruction in a medical college in the treatment of human ailments, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, and in addition thereto, a course of clinical training of not less than 12 months in a hospital, such college of liberal arts, medical college and hospital having been the department.

The time requirement of not less than 132 weeks within a period of 35 months, set forth above, may be reduced by the department upon recommendation of the Dean of the medical school in the case of programs involving students with advanced standing. (added by Act approved July 26, 1971).

(c) For an applicant who is a graduate of a medical college or school in another country; that such applicant was a resident of this State for a period of five years prior to matriculating in such medical college or school; that such applicant completed a required course of instruction in the treatment of human ailments as offered by such college or school of medicine, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of three years course of instruction in an accredited college of liberal arts or its equivalent; that such applicant submit an application to an Illinois medical school and submit to such testing procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school, to determine equivalency of education compared to state norms, such testing could be utilized in placement of such applicant at a level appropriate to educational achievement; that such applicant may be placed by an Illinois medical school into the appropriate level of medical school, thru internship training, provided that applicant agrees to pay, either by a scholarship or some other personal means, such tuition and fees necessary to complete medical education, and provided that such applicant signs a statement in a form to be determined by the Department that upon successful completion of all licensure requirements applicant intends to practice medicine in this State. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicant shall be eligible for award of an M.D. degree and examination and licensing for the practice of medicine in all of its branches as provided in this act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

(d) Until September 1, 1978, for an applicant

who has studied medicine at a medical college or school located outside the United States; that such applicant has completed all of the formal requirements of a foreign medical school except internship and/or social service, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of 3 years course of instruction in an accredited college of liberal arts or its equivalent; that such an applicant has submitted an application to a medical school recognized by the Department and submitted to such evaluation procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school and that such applicant has satisfactorily completed one academic year of supervised clinical training under the direction of such medical school; and, after completion of said academic year of supervised clinical training, that such applicant has satisfactorily completed twelve months of post graduate training in an approved hospital having been repeatable and in good standing in the judgment of the Department; and provided that such applicant sign a statement and a form, to be determined by the Department, that upon successful completion of all license requirements, applicant intends to practice medicine in this state. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicants shall be eligible for examination and licensing for the practice of medicine in all of its branches as provided in this Act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

Until September 1, 1978, satisfaction of the requirements of this sub-section shall be in lieu of the completion of any foreign internship and/or social service requirements, and no such requirements shall be a condition of licensure as a physician in this State.

Until September 1, 1978, satisfaction of the requirements of this sub-section shall be in lieu of certification by the Educational Council for Foreign Medical Graduates, and such certification shall not be a condition of licensure as a physician in this State for candidates who have completed the requirements of this sub-section.

Until September 1, 1978, no hospital licensed by the State, or operated by the State or political subdivision thereof, or which receive State financial assistance, directly or indirectly, shall require an individual who at the time of his enrollment in a medical school outside the United States is a citizen of the United States, to satisfy any requirement other than those contained in this sub-section prior to commencing an internship or residency.

Until September 1, 1978, a document granted by a medical school located outside the United States which certifies completion of all of the formal training requirements of such foreign medical school except internship and/or social service; and satisfactory completion of the examination and academic year of supervised clinical training at a medical

school recognized by the Department referred to in this sub-section shall be deemed the equivalent of the degree of Doctor of Medicine for purposes of licensure and practice as a physician in this State and shall possess all the rights and privileges thereof.

The Illinois Board of Higher Education may make grants to Illinois Medical Schools, public and private, for each applicant who commences his academic year of supervised clinical training under the direction of said medical school. Preference shall be given in the award of these grants to Illinois residents. The Illinois Board of Higher Education shall by regulation adopt reasonable guidelines for the distribution of funds authorized by this Act. (Added by Act approved Sept. 7, 1974).

*2. Treating human ailments without drugs or medicines and without operative surgery.* For the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery:

(a) For an applicant who was a resident student and who is a graduate before July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments, which he specifically designated in his application as the one he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to graduation a 3 years' course of instruction of not less than 6 months each, the time elapsing between the beginning of the first year and the ending of the third year having been not less than 22 months, and which are reputable and in good standing in the judgment of the department and prior to taking the examination the applicant must present proof that he has completed a 4 years' course of instruction in high school, or its equivalent, as determined by an examination conducted by the department.

(b) For an applicant who was a resident student and who is a graduate after July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments which he specifically designated in his application as the one which he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to admission thereto a 4 years' course of instruction in a high school, and as a prerequisite to graduation therefrom a course of instruction in the treatment of human ailments, of not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months except that as to students matriculating or entering upon a course of study of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery during the

years 1940, 1941, 1942, 1943, 1944, 1945, 1946 and 1947, the said elapsed time shall be not less than 32 months, such high school and such school, college, institution having been reputable and in good standing in the judgment of the department.

(c) For an applicant who is a matriculant in a chiropractic college after September 1, 1969, that such applicant shall be required as a prerequisite for admission to examine for licensure, to complete a 2 years' course of instruction in a liberal arts college or its equivalent, and a course of instruction in a chiropractic college in the treatment of human ailments, such course as a prerequisite to graduation therefrom having been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, such college of liberal arts and chiropractic college having been reputable and in good standing in the judgment of the Department.

*3. Midwifery.* For the practice of midwifery: That he be a graduate of a college of midwifery which requires as a prerequisite to admission thereto, a one year's course of instruction in a high school or its equivalent, and required as a prerequisite to graduation, a one year's course in such college of midwifery, the time actually spent under instruction in such college of midwifery to have been not less than 12 months; such high school or equivalent school, and such college of midwifery having been in good standing in the judgment of the department.

Without prejudice to licenses heretofore issued under this section, no further licenses shall be issued under this section after the effective date of this amendment. As amended by act approved Aug. 2, 1965.

All examinations provided for by the Medical Practice Act shall be conducted by the Department of R&E. Examinations of applicants who seek to practice medicine in all of its branches shall embrace the subjects of which knowledge is generally required of candidates for the degree of Doctor of Medicine by reputable medical colleges in the U.S., and shall be such in the judgment of the Department of R&E that as will determine the qualifications of applicants to practice medicine in all of its branches.

Every license issued under the Act expires on July 1 of each even-numbered year. Every licensee under the Act may, biennially during the month of June of each even-numbered year, renew his license upon paying to the Department a renewal fee of \$10.

#### REVOCATION AND SUSPENSION OF LICENSE OR CERTIFICATE

The Department may revoke, or suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license, certificate or state hospital permit of any person issued under this Act or under any other Act in this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery, or may refuse to grant a license, certificate or state hospital permit under this Act or may grant a license, certificate or state hospital permit on a probationary status subject to the limitations of the probation, and may cause any license or certificate which has been the subject of formal disciplinary procedure to be marked accordingly on the records of any county clerk upon the following grounds:

- "1. Conviction of procuring or attempting or aiding to procure such an abortion as was made unlawful at the time under the Criminal Code of this State;
2. Conviction in this or another state of any crime which is a felony under the laws of this state or conviction of a felony in a federal court, if the Department determines, that after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust; (as amended by Act approved July 23, 1971).
3. Gross malpractice resulting in permanent injury or death of a patient;
4. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;
5. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;
6. Habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to incapacitate for performance of professional duties;
7. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;
8. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery, or in passing an examination therefor, or willful and fraudulent violation of the rules and regulations of the department governing examinations;

9. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill or the efficacy or value of one's medicine, treatment or remedy therefor;
10. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;
11. Revocation or suspension of a medical license in a sister state;
12. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;
13. Except as otherwise provided in Section 16.01, advertising or soliciting by himself or through another, by means of hand bills, posters, circulars, stereopticon slides, motion pictures, radio, newspapers or in any other manner for professional business."
14. A finding by the Committee that the registrant after having his license placed on probationary status violated the terms of the probation.

All proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to a license, certificate or state hospital permit on any of the foregoing grounds, except the ground numbered 8 (fraudulent groups expected) must be commenced within 3 years next after the conviction or commission of any of the acts described therein, except as otherwise provided by law; but the time during which the holder of the license, certificate or state hospital permit was without the State of Illinois shall not be included within the 3 years.

The entry of a decree by any circuit court establishing that any person holding a license, certificate or state hospital permit under this Act is a person in need of mental treatment operates as a suspension of that license, certificate or state hospital permit. That person may resume his practice only upon a finding by the Committee of Physicians that he has been determined to be recovered from mental illness by the court and upon the Committee's recommendation that he be permitted to resume his practice. (added by Act approved July 26, 1971).

15. Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional

services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act" as now or hereafter amended or as an association authorized by "The Professional Association Act" as now or hereafter amended, or under "The Professional Corporation Act" as now or hereafter amended, from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection shall abrogate the right of two or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divided a fee: provided, the patient has full knowledge of the division, and provided that the division is made in proportion to the services performed and responsibility assumed by each. (added by Act approved July 31, 1971).

Section 16.01. Any person licensed under this Act may list his name, title, office hours, address, telephone number and any specialty in professional and telephone directories; may announce by way of a professional card not larger than 3½ inches by 2 inches, only his name, title, degree, office location, office hours, phone number, residence address and phone number and any specialty; may list his name, title, address and telephone number and any specialty in public print limited to the number of lines necessary to state that information; may announce his change of place of business; absence from, or return to business in the same manner; or may issue appointment cards to his patients, when information thereon is limited to the time and place of appointment and that information permitted on the professional card. Listings in public print, in professional and telephone directories, or announcements of change of place of business, absence from, or return to business, may not be made in bold faced type.

**Rules and Regulations Adopted for the Administration of the Illinois Medical Practice Act, Effective March 18, 1955**

**RULE I—ACCREDITED COLLEGES OF MEDICINE AND SURGERY**

Medical colleges having rules and curricula commensurate with and equivalent to the rules and curricula of the College of Medicine of the University of Illinois, will be considered for ac-

creditation by the Department of Registration and Education.

**RULE II—ACCREDITED COLLEGES TEACHING SYSTEMS OF TREATING HUMAN AILMENTS WITHOUT THE USE OF DRUGS OR MEDICINE AND WITHOUT OPERATIVE SURGERY.**

A professional college or institution teaching a system of treating human ailments without the use of drugs or medicine and without operative surgery shall be deemed reputable and in good standing in the judgment of the Department upon submission of proof of the following requirements:

(a) That a Dean or other Executive Officer, employed on a full-time basis supervises the students and curriculum.

(b) That the faculty is comprised of graduates in their specialty from recognized professional colleges or institutions.

(c) That the faculty is organized and each department has a director, professors, associate professors and assistant professors, each responsible to his superior for his instruction in the particular subject he teaches.

(d) That, annually, a catalogue or brochure is published setting forth the requisites for admission to the college, tuition rates, courses offered, dates of sessions, schedule of classes, requirements for graduation, a roster of the undergraduate students and a roster of the last graduating class. The catalogue or brochure shall contain a list of the departments of the school, the titles of the personnel and a brief summary of each person's qualifications. The curriculum shall include, but not be limited to, four academic years' instruction in the following subjects:

(1) Anatomy

(a) Embryology; (b) Histology; (c) Neuro-anatomy

(2) Physiology and Chemistry

(3) Pathology and Bacteriology

(4) Diagnosis

(a) Physical; (b) Differential; (c) Laboratory

(e) That suitable buildings provided with laboratories equipped for instruction in anatomy, chemistry, physiology, bacteriology and other areas of learning necessary to the due course of study prescribed by these rules; and that a laboratory equipped with supplies, models, manikins, charts, stereopticon, roentgen-ray and other special apparatus used in teaching the system to treat human ailments without the use of medicine and operative surgery, be provided.

(f) That a working library, easily accessible to students, is maintained from at least 9 a.m. to 5 p.m., with a librarian in constant attendance. The library shall contain a standard medical dictionary, the modern text and reference books, and the files of leading periodicals dealing with the particular system of treating human ailments with-

out the use of medicine and operative surgery.

(g) That the college or institution requires all students to furnish, before matriculation, satisfactory proof of the preliminary education required by the Medical Practice Act.

(h) That full and complete records are kept showing the credentials for admission, attendance, grades and financial accounts of each student.

(i) That admission of transfer students will be limited to honorably dismissed students from another approved college or institution teaching the same system. The transcript of record obtained directly from the transferring school shall be kept on file. It shall be the duty of a college or institution to furnish such a transcript for the benefit of each student subject to honorable dismissal. No credit shall be given a transferred student for final or "senior year" work or for any courses taken by correspondence.

(j) That students shall start class attendance within one week of the start of each session. That credit for completion of a course will not be granted a student who failed to attend 80 per cent of the complete session of the course.

### RULE III—HOSPITALS APPROVED FOR INTERNSHIP.

1. A hospital shall, in the judgment of the Department, be deemed reputable and in good standing for training interns and intern services when it meets the following standards:

(a) General hospital of 150 beds' capacity, with an average of at least 60 patients daily, with rotating service.

(b) Shall contain at least the departments of internal medicine, surgery, obstetrics and pediatrics; and an organized departmentalized staff, holding meetings monthly for case reviews and study.

(c) Laboratory employing a full-time qualified technician and at least a part-time qualified pathologist, visiting the laboratory at least two days per week.

(d) Radiological department employing a qualified X-ray technician and at least a part-time qualified roentgenologist, visiting the department at least two days per week.

(e) Maintenance of an up-to-date medical library located in a suitable study room available to interns.

(f) Such hospital shall provide and furnish the Department with the names of staff members of the various departments of the hospital.

(g) The hospital, upon the completion of a course of training therein of not less than twelve months, shall issue its certificate therefor to any such intern or at the request of the Department, such certificate shall include therein, by date, the commencement and the conclusion thereof.

2. An approved internship shall consist of twelve

months rotating service in medicine, surgery, obstetrics and pediatrics, with an election in medical specialties.

In the event an applicant has received training in excess of the twelve months' period specified by the Medical Practice Act, and if this be in an institution approved by the Department as adequate for specialty training; and if the applicant has received certification by a recognized Medical Specialty Board, and has had two or more years' specialty practice or Military Service; such training and practice may be accepted as the equivalent of a rotating internship.

Any applicant who shall have completed twelve months of clinical training in a hospital, as required by Section 5-1(b) of the Medical Practice Act, and who has been accepted for further training in a specialty or general practice residency program by a hospital or institution approved by the Department for that purpose, shall be deemed to have complied with the requirements of this rule and of the Medical Practice Act in this regard.

### RULE IV—APPLICATION FOR EXAMINATION

An applicant for examination for licensure to practice medicine in all of its branches, or any system of treating human ailments without the use of drugs or medicine and without operative surgery, must make application on forms furnished by the Department at least fifteen days prior to the examination and present, in addition:

(a) Recommendations from two (2) physicians duly licensed to practice in some state in the United States.

(b) A recent photograph, passport size, signed by applicant and two persons licensed to practice the system of treatment of human ailments for which the applicant is seeking a license. A duplicate photograph must be presented with the card of admission at the examination.

(c) The original diploma of graduation from the professional college in which the applicant completed his course of training, or, in lieu of presenting the diploma with the application, the applicant may present it at the examination.

(d) A certified copy of secondary school and professional school studies to be mailed direct to the Department by the schools attended or by the professional schools where the applicant completed the required course of study.

(e) Proof of completion of a rotating internship of twelve months in an approved hospital for applicants seeking admission to examination for license to practice medicine in all of its branches; and, in the case of graduates of medical colleges in countries other than the United States and Canada, who apply for examination after January 1, 1953, proof of ro-

tating internships of one year in approved hospitals in the United States.

A candidate under Section 5, paragraph 1-b, or Section 13, may apply for the examination or clinical test and take the examination given immediately prior to completion of his internship provided he furnishes a statement from the hospital authorities stating his internship has been satisfactory to date. The results of the examination will be withheld and no license will be issued until the Department receives proof of satisfactory completion of the required internship in an approved hospital training program.

(f) Applicants who completed their medical courses in the extramural colleges of Ireland and Scotland shall not be eligible for admission to examinations for licensure under the Illinois Medical Practice Act.

(g) Graduates of European medical colleges or universities after January 1, 1943, with the exception of certain approved colleges in the British Isles, Denmark, Holland, Norway, Sweden and Switzerland, be not accepted for admission to examinations for licensure under the Illinois Medical Practice Act.

Graduates of such European medical colleges after January 1, 1943 may be considered for admission to Illinois examinations provided they present diplomas of graduation from approved medical colleges in the United States after attendance in such colleges for at least one year; and in addition, have served rotating internships of one year in approved hospitals in the United States.

(h) An applicant who presented a diploma of graduation from an approved school will not be accepted, if he was accorded advanced standing in such school based upon his prior education in an unapproved school.

## RULE V—EXAMINATIONS

1. Examinations for licensure to practice medicine in all of its branches shall be conducted in the English language and shall be in the following theoretical and practical areas of medicine:

### THEORETICAL

Chemistry, Physiology, Anatomy, Pharmacology, Pathology, Bacteriology, Medicine, Public Health & Preventive Medicine, Obstetrics & Gynecology, Surgery, Pediatrics, Psychiatry

### CLINICAL

General Practice of Medicine

2. Examinations for licensure to practice the treatment of human ailments without the use of drugs or medicine and without operative surgery shall be conducted in the English language and shall be in the following theoretical and practical subjects:

### THEORETICAL

Chemistry & Physiology, Anatomy & Histology, Pathology & Bacteriology, Diagnosis, Hygiene & Medical Jurisprudence, Eye, Ear, Nose, & Throat, Dermatology, Pediatrics & Neurology, System of Practice, Obstetrics (for graduates of approved osteopathic colleges)

### PRACTICAL

System of Practice

3. To be successful, applicants must receive general averages of 75% with no grade below 60% in the written examination, and a general average of 75% in the clinical or practical test.

Applicants applying for registration under Sections 12 and 12a of the Medical Practice Act shall be required to make general averages of 75% in the three subjects required for license to practice medicine and surgery in Illinois.

4. In case of failure in the first and second examinations applicants will be allowed credit on the following examination for all grades of 75% or more; but in case of failure in the third examination they must retake all written subjects at each subsequent examination. It is not required that the clinical or practical part of the examination be repeated after a passing grade of 75% has been received in that part of the examination.

5. Applicants who take the regular written examination conducted by the Department for licenses as Physicians and Surgeons shall be excused from taking the clinical test.

6. An applicant for registration as Physician and Surgeon who has been unsuccessful in five examinations will be deemed to be eligible for further examination upon receipt of proof that he has completed one year of residency training in an approved hospital training program in the United States received subsequent to the applicant's fifth failure.

7. An applicant who has been unsuccessful in five examinations for registration as a drugless practitioner will be eligible for reexamination upon receipt of proof that he has completed a course of study of 960 hours in a school which is accredited under the Medical Practice Act. This course must be received subsequent to the applicant's fifth failure.

8. An applicant who furnished proof of a course of study of 240 hours in a school of chiropractic recognized by the Department in order to be eligible for further examination under Section 9a of the Medical Practice Act will be considered as a new applicant and his grades of 75 per cent or more will be carried over to the second and third examinations.

## RULE VI—RECIPROCITY

1. Each applicant for registration through reciprocity, either for the practice of medicine in all

of its branches or for the treatment of human ailments without the use of drugs or medicine and without operative surgery, filed on forms provided by the Department, will be considered on its individual merits, provided the state or territory of original licensure grants a like privilege to persons licensed in Illinois.

2. If the application is not endorsed by officers of a state or county society it must be endorsed by two (2) physicians duly licensed to practice in some state in the United States.

3. Applicants for licensure through reciprocity or upon the basis of having passed the National Board Examination prior to January 1, 1964, must pass the clinical test conducted by this Department. Applicants upon the basis of the National Board Examination who completed Part III after January 1, 1964, are required to report for an interview with the Medical Examining Committee. The clinical test shall be such in the judgment of the Committee as will determine the qualifications of the applicant to practice medicine in all of its branches, taking into consideration the quality of medical education and clinical training or practical experience which the applicant has had, special honors or awards, publications in recognized and reputable journals, authorship of textbooks in medicine, and any other circumstance or attribute that the Committee accepts as evidence of an outstanding and proven ability in any branch of the field of medicine.

4. Graduates of Chiropractic colleges whose applications for registration in Illinois by reciprocity are approved, shall be required to pass a written examination in theory in addition to a practical test before the chiropractic examiner.

#### RULE VII—LICENSURE

1. An examinee who successfully completes his medical examination must secure his certificate of licensure within one year from the date of his examination.

2. The Department will not issue a duplicate certificate of registration to practice medicine in all of its branches, or to treat human ailments without the use of drugs or medicine and without operative surgery, unless proof satisfactory to the Department and the Committee is presented that the original certificate was destroyed; or in case of change of name when the original certificate is returned for cancellation, together with satisfactory legal proof of such change of name.

3. A license to practice medicine in Illinois shall be a requisite for a residency in an Illinois hospital.

#### RULE VIII—TEMPORARY CERTIFICATES OF REGISTRATION

1. Any person not licensed to practice medicine

in all of its branches in the State of Illinois who wishes to pursue a program of graduate or specialty or residency training in this State, must be the holder of a Temporary Certificate of Registration issued by the Department under the provisions of Section 11a of the Medical Practice Act of Illinois and in accordance with the provisions of the within Rules.

2. Application for a Temporary Certificate must be made on blank forms prepared and furnished by the Department. It must be submitted to the Department together with evidence satisfactory to the Department that applicant meets the requirements of Section 11a of the Illinois Medical Practice Act and that if his application is approved he will be accepted or appointed for the residency training in the hospital designated in such application.

3. A Temporary Certificate of Registration will be issued on behalf of an otherwise qualified applicant only for residency or specialty training in a hospital situated in this State which is approved by the Department for the purpose of such training. An approved hospital is one which in the judgment of the Department is qualified to offer such training, and which shall comply with the within Rules.

4. Written notice of the Department's final action on every application for a Temporary Certificate of Registration shall be given to the applicant and the hospital designated therein; when such application is approved the Temporary Certificate of Registration shall be delivered or mailed to the hospital designated therein and shall be kept in the care and custody of such hospital. The applicant shall not commence such specialty or residency training before he or the hospital receives written notification of approval of his application.

5. A Temporary Certificate of Registration shall not be valid for longer than one year after issuance thereof and may be renewed from time to time, in the discretion of the Department, for a period of not more than one year each time. Application for renewal must be made on forms prepared and furnished by the Department and the Temporary Certificate of Registration sought to be renewed must be submitted therewith to the Department.

6. When any person in whose behalf a Temporary Certificate of Registration has been issued shall be discharged or shall terminate his specialty or residency training in the hospital designated therein, such hospital shall immediately deliver or mail by registered mail to the Department his Temporary Certificate of Registration and written notice of the reason for return of same.

7. A Temporary Certificate of Registration is not transferable without prior notice to and approval by the Department. If the holder of a

Temporary Certificate of Registration wishes to change to another training program in the approved hospital designated therein, or he wishes to enter a training program in another approved hospital, he must make application on Forms furnished by the Department. His current Temporary Certificate of Registration must accompany such application and he cannot thereafter continue in the training program designated on such current Certificate, and he may not commence such other training program until a Temporary Certificate of Registration has been issued therefor.

8. Not more than one Temporary Certificate of Registration shall be issued to any person for the same period of time. A person on whose behalf a Temporary Certificate of Registration has been issued is limited in the practice of medicine to the performing of such acts as may be prescribed by and incidental to his program of residency training in the hospital designated in his Temporary Certificate of Registration, and he cannot otherwise engage in the practice of medicine in the State of Illinois.

9. Whenever, under the within Rules, a hospital is required to deliver or return a Temporary Certificate of Registration to the Department, in case, because of the loss or destruction of such Certificate, or for any other reason, such hospital shall be unable immediately so to deliver or mail such Certificate, such hospital shall immediately mail or deliver to the Department a written explanation in detail of such inability.

10. The holder of a Temporary Certificate of Registration is not barred thereby from becoming eligible for admission to the Department examination for a license to practice medicine in Illinois if he otherwise meets the requirements for admission to such examination and if such person should fail to pass such examination such failure shall not bar him from completing his training program.

#### RULE IX—LIMITED LICENSES TO PRACTICE IN STATE HOSPITALS

1. Each application made on forms provided by the Department will be considered on its own merits.

2. The State Hospital at which the applicant will practice under the supervision of a medical officer, shall signify to the Department that the hospital will appoint the applicant in the event he receives a Limited License.

3. Any applicant for a Limited License who has failed in more than three examinations for licensure under the Illinois Medical Practice Act shall not be eligible for a Limited License.

4. State hospital permits of physicians not otherwise licensed to practice may be renewed only once after July 1, 1975, for a one year period, with all original permits and renewals to expire

on July 1 after issuance. After July 1, 1975, all permit holders seeking renewal will be required to pass new examination given by Department of Registration and Education, or an equivalent examination.

#### ECFMG REQUIREMENTS

The Education Council for Foreign Medical Graduates (ECFMG) commenced operations in October, 1957. Sponsors of this agency are the American Hospital Association, American Medical Association, Association of American Medical Colleges, and Federation of State Medical Boards of the United States. ECFMG gives two examinations a year to foreign medical graduates. The examinations test the graduate's general knowledge of medicine and command of English.

Persons successfully passing this examination are granted an ECFMG certificate. This certificate in the State of Illinois is **not a substitute** for nor is it the equivalent of licensure to practice medicine. It simply indicates that the holder's command of English has been tested and found adequate for assuming an internship in an American hospital. The holder of such a certificate may not practice medicine in any degree in a hospital in Illinois unless he is within one of the categories outlined above.

#### Offenses Listed

An unlicensed person who commits any of the following acts regardless of whether the same be committed within or without a hospital is guilty of practicing medicine without a license—a criminal offense:

1. Hold himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings.
2. Suggest, recommend or prescribe any form of treatment for the palliation, relief or cure of any physical or mental ailment of a person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever.
3. Diagnosticate or attempt to diagnosticate any ailment or supposed ailment of another.
4. Operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment of another.
5. Maintain an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment.
6. Attach the title Doctor, Physician, Surgeon, M.D., or any other word or abbreviation to his name, indicative that he is engaged in the treatment of human ailments as a business.

(*Medical Practice Act. [Chp. 91, Sec. 16i, Paragraph 24, 1973 Rev. Stat.]*)

Manifestly, the enforcement of the Medical Practice Act with respect to the elimination of unlicensed persons practicing medicine in a hospital is dependent upon co-operation by responsible persons within the hospital. It should be noted that lack of co-operation or failure to meet responsibilities can in a proper case be translated into criminal liability and disciplinary action resulting in revocation or suspension of a license to practice medicine as follows:

1. The unlicensed person practicing medicine is committing a criminal offense.
2. A hospital administrator who assigns an unlicensed person to duties which involve his practicing medicine may subject himself to the criminal offense of aiding and abetting such unlicensed person to illegally practice medicine, and the same may be true of a hospital chief of staff or department head if in the nature of his duties he is directly responsible for assigning such duties to the unlicensed person.
3. A licensed doctor may have his license suspended or revoked if he has professional connection or association with another who is illegally practicing medicine. A chief of staff who knowingly allows such person to illegally practice medicine, or in a proper case, any member of the medical staff of a hospital may subject himself to disciplinary action against his license.
4. A licensed doctor may have his license suspended or revoked for unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

A member of the medical staff of a hospital may place himself within such conduct if he neglects, fails or refuses to fulfill his responsibilities while on emergency room call.

### **Other Examining Boards**

Other examining boards operating under the jurisdiction of the Department of Registration and Education are:

*Dental Examining Committee*  
William T. Osmanski, D.D.S., Wilmette, *Chairman*  
Hugh D. Burke, D.D.S., Dixon  
Laurence Ginestra, Rockford  
Silas P. Jones, D.D.S., Chicago  
Richard A. Kozal, D.D.S., Summit  
Ogden Munroe, Springfield  
William L. Podesta, D.D.S., Mattoon

*Committee of Nurse Examiners*  
Mary Ann Santucci, Winfield, *Chairman*  
Charlotte P. Anders  
Maxine Brower, Taylorville  
Joyce Griffin, Springfield  
Louise Guest, Peoria  
Christopher Hannan, Chicago  
Mary Kochyeonos, Elmhurst  
James Larabee, Danville  
Juanita Stewart, Chicago

*Illinois Optometric Examining Committee*  
Robert W. Stoelzle, O.D., Carbondale, *Chairman*  
Henry R. Moore, Chicago  
Gene Ossello, O.D., Dolton  
Richard L. Stratton, O.D., Springfield  
Floyd Woods, O.D., Oak Lawn

*State Pharmacy Board*  
Louis Gdalman, Chicago, *Chairman*  
John Barlow, Sullivan  
Richard Hilden, Downers Grove  
Fred L. Jones, Avon  
Dr. Daniel Nona, Chicago  
Philip Sacks, Norridge  
Irwin S. Thornton, Chicago

*Physical Therapy Examining Committee*  
Miss Vilma Evans, Danville, *Chairman*  
Robert Babbs, Jr., Chicago  
James Mason Gray, Springfield  
John J. Mustari, Oak Lawn  
Arthur A. Rodriguez, M.D.

*Podiatry Examining Committee*  
Charles H. Delano, DPM, Springfield, *Chairman*  
Dr. Joseph M. Giannini, DPM, Chicago  
Joseph B. Rubino, DPM, Elmwood Park

*Psychologist Examining Committee*  
Dr. Frank Kobler, Chicago, *Chairman*  
Dr. Morris Aderman, Skokie  
Dr. Frank Costin, Champaign  
Dorothy Jean Dettmar, Hinsdale

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## **DIVISION OF VOCATIONAL REHABILITATION**

623 East Adams Street  
Springfield, IL. 62706  
Eugene P. Turner, *Director*

The Board of Vocational Education and Rehabilitation is a statutory body, established to administer, through two operating divisions, the state program of vocational and technical edu-

cation pursuant to the Federal Vocational Education Act, as amended, and the state program of vocational rehabilitation pursuant to the Federal Vocational Rehabilitation Act as amended.

## **Board of Vocational Education and Rehabilitation**

### **Statutory Members:**

Mary Lee Leahy, Director  
Department of Children & Family Services  
Suite 1713, 160 N. LaSalle St., Chicago 60601

Robert J. Williams, Director  
Department of Agriculture  
Junior Livestock Bldg., State Fairgrounds  
Springfield 62706

Kenneth W. Holland, Director  
Department of Labor  
704 State Office Building, Springfield 62706

LeRoy P. Levitt, M.D., Director  
Department of Mental Health  
Rm. 1500, 160 N. LaSalle St., Chicago 60601

Michael J. Bakalis, Ph.D.  
Superintendent of Public Instruction  
302 State Office Building, Springfield 62706

Joyce C. Lashof, M.D., Director  
Department of Public Health  
535 W. Jefferson Street, Springfield 62706

Ronald Stackler, Director  
Department of Registration & Education  
628 E. Adams Street, Springfield 62706

### **Lay Members:**

*Chairman of the Board:*  
Dorothy Grant Arndt  
1330 26th Avenue, Rock Island 61201

Frank C. Bacon, Jr.  
Sears Bldg., 403 South State Street, Chicago 60605

Harold Byers  
2218 Park Hill Drive, Highland 62249

Mary E. McKean  
447 Arlington, Elmhurst 60126

Emmett Palmer  
6 N. 431 Gary Avenue, Keeneyville

Tony Vasquez  
2645 South Christiana, Chicago 60623

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## **ILLINOIS REGIONAL MEDICAL PROGRAM REGIONAL ADVISORY GROUP**

The Illinois Regional Medical Program, which began in 1967, is a federally funded but autonomous organization charged with improving the health care of the citizens of the state of Illinois. The program goals objectives are a single standard of high quality health care, provided with maximum effectiveness at minimal cost, and accessible to all. The IRMP helps reach those goals by supporting and engaging in activities aimed at fulfilling the following health care objectives: 1) improved understanding of health and health care (public education); 2) optimum deployment of entry points to the health care system (primary care); 3) optimum relationship of the components of the health care system to each other (regionalization); 4) optimum availability of human and technical resources for the health care system (manpower and technology); and 5) assurance and maintenance of high quality care. The Regional Advisory Group, the policy-making body of the IRMP, must approve all project applications for funding. The RAG is composed of representatives from the medical profession, allied health professions, hospital administration, planning agencies, voluntary and official health groups, medical schools and teaching hospitals in the state, as well as members of the general public familiar with the financing of, and the need for, health care.

### **Regional Advisory Group**

Dexter Nelson, M.D., Princeton, *Chairman*  
Leonidas H. Berry, M.D., Chicago  
Daniel K. Bloomfield, M.D., Urbana  
Josephine Brandt, R.N., Moline  
Andrew Brislen, M.D., Chicago  
Edgar Britton, Chicago  
Murray C. Brown, M.D., Chicago  
Donald J. Cascley, M.D., Chicago  
Jacob Cates, Belvidere  
Donald P. Colleton, Chicago  
Effie O. Ellis, M.D., Chicago

Velma Evans, R.P.T., Danville  
Stanley Goldstein, M.D., Decatur  
Charles R. Goulet, Chicago  
Arthur L. Grist, Edwardsville  
William J. Grove, M.D., Chicago  
Emanuel Hallowitz, Chicago  
William Hejna, M.D., Chicago  
Irwin M. Jarett, Ph.D., Springfield  
Sister Clementia Jerome, A.S.C., Taylorville  
Allen Kelly, Eldorado  
Richard H. Kessler, M.D., Chicago  
Robert A. Kistner, D.O., M.D., Chicago  
Marion Lamet, Warsaw  
Joyce C. Lashof, M.D., Springfield  
August P. Lemberger, Ph.D., Chicago  
Mark H. Lepper, M.D., Chicago  
LeRoy P. Levitt, M.D., Chicago  
Henry J. Luckhardt, O.D., Westmont  
W. Henderson May, Springfield  
Harold W. Maysent, Rockford  
Frances McCann, R.N., M.Ed., River Grove  
George M. O'Neill, Carbondale  
Robert J. Parker, M.D., Bloomington  
Caesar Portes, M.D., Chicago  
Morris Profit, M.D., Chicago  
Paul Raczkiewicz, Granite City  
Will Rasmussen, Chicago  
Barbara Rohrer, Peoria  
Edward F. Scanlon, M.D., Evanston  
Barry Seng, M.D., Morris  
Maynard Shapiro, M.D., Chicago  
Hiram Sibley, Chicago  
Weathers Y. Sykes, Chicago  
A. Nichols Taylor, Ph.D., Chicago  
John C. Troxel, M.D., Chicago  
Sheldon Wallach, D.D.S., Glenwood  
J. A. Wells, M.D., Maywood  
Perry Whiteside, Chicago

## POISON CONTROL CENTERS IN ILLINOIS

For further information contact:  
Byron J. Francis, M.D., M.P.H., Chief  
Division of Disease Control  
Illinois Department of Public Health  
535 W. Jefferson  
Springfield, 62761  
Phone: (217) 782-3300

### ALTON

Alton Memorial Hospital  
Memorial Drive  
(618) 462-8851

### AURORA

Copley Memorial Hospital  
Lincoln & Weston Avenues  
(312) 897-6021, Ext. 725 or 726; 896-3911 Direct line

### BELLEVILLE

Memorial Hospital  
4501 North Park Drive  
(618) 233-7750, Ext. 250

### BELVIDERE

Highland Hospital  
1625 S. State Street  
(815) 547-5441

### BERWYN

MacNeal Memorial Hospital  
3249 S. Oak Park Avenue  
(312) 797-3000 or 797-3159

### BLOOMINGTON

Mennonite Hospital  
807 North Main Street  
(309) 828-5241, Ext. 312  
St. Joseph's Hospital  
2200 E. Washington  
(309) 662-3311, Ext. 352

### CAIRO

Padco Community Hospital  
2020 Cedar Street  
(618) 734-2400, Ext. 42

### CANTON

Graham Hospital Association  
210 W. Walnut Street  
(309) 647-5240, Ext. 230 or 248

### CARBONDALE

Doctors Memorial Hospital  
404 West Main Street  
(618) 549-0721, Ext. 341

### CARTHAGE

Memorial Hospital  
End of South Adams Street  
(217) 357-3131, Ext. 84

### CENTRALIA

St. Mary's Hospital  
400 North Pleasant Avenue  
(618) 532-6731, Ext. 716

### CHAMPAIGN

Burnham City Hospital  
407 South 4th  
(217) 337-2533

### CHANUTE AIR FORCE BASE

United States Air Force Hospital  
(217) 495-3133 or 495-3134  
Limited for treatment of military personnel  
and families, except for indicated civilian  
emergencies

### CHESTER

Memorial Hospital  
1900 State Street  
(618) 826-4581

### CHICAGO

MASTER CHICAGO CENTER for information, treatment  
and reference on poisonings

RUSH-PRESBYTERIAN-ST. LUKES MEDICAL CENTER  
1753 West Congress Parkway  
(312) 942-5969

Children's Memorial Hospital  
2300 Children's Plaza  
(312) 649-4161

Cook County Children's Hospital  
700 South Wood Street  
(312) 633-6539

Mercy Hospital  
Stevenson Expressway & Martin Luther King Dr.  
(312) 567-2200

Michael Reese Medical Center  
29th and Ellis Avenue  
(312) 791-2810

Mt. Sinai Hospital  
California at 15th Street  
(312) 542-2030

Resurrection Hospital  
7435 West Talcott Avenue  
(312) 774-8000, Ext. 401

St. Mary of Nazareth Hospital Center  
1120 North Leavitt  
(312) 292-5319

University of Illinois Hospitals  
840 South Wood Street  
(312) 996-6885

Wyler Children's Hospital  
950 East 59th Street  
(312) 947-6231

### DANVILLE

Lake View Memorial Hospital  
812 North Logan Avenue  
(217) 443-5221

St. Elizabeth Hospital  
600 Sager Avenue  
(217) 442-6300

### DECATUR

Decatur Memorial Hospital  
2300 North Edward Street  
(217) 877-8121, Ext. 676

St. Mary's Hospital  
1800 East Lakeshore Drive  
(217) 429-2966, Ext. 644

### DES PLAINES

Holy Family Hospital  
100 North River Road  
(312) 297-1800, Ext. 1000

### EAST ST. LOUIS

Christian Welfare Hospital  
1509 Martin Luther King Drive  
(618) 874-7076, Ext. 216 or 232; 398-1178 Direct line

**St. Mary's Hospital**  
 129 North 8th Street  
 (618) 274-1900, Ext. 204, 268 or 283  
**EFFINGHAM**  
**St. Anthony Memorial Hospital**  
 503 North Maple Street  
 (217) 342-2121, Ext. 211 or 212  
**ELGIN**  
**St. Joseph Hospital**  
 77 Airlite Street  
 (312) 695-3200 Ext. 348  
**Sherman Hospital**  
 934 Center Street  
 (312) 742-9800, Ext. 681 or 682  
**ELMHURST**  
**Memorial Hospital of DuPage County**  
 209 Avon Road  
 (312) 833-1400, Ext. 550  
**EVANSTON**  
**Evanston Hospital**  
 2650 Ridge Avenue  
 (312) 492-6460  
**St. Francis Hospital**  
 355 Ridge Avenue  
 (312) 492-2440  
**EVERGREEN PARK**  
**Little Company of Mary Hospital**  
 2800 West 95th Street  
 (312) 445 6000, Ext. 221  
**FAIRBURY**  
**Fairbury Hospital**  
 519 South Fifth Street  
 (815) 692-2346, Ext. 248  
**FREEPORT**  
**Freeport Memorial Hospital**  
 420 South Harlem Avenue  
 (815) 233-4131, Ext. 228  
**GALESBURG**  
**Galesburg Cottage Hospital**  
 695 North Kellogg  
 (309) 343-4121, Ext. 336  
**St. Mary's Hospital**  
 239 South Cherry Street  
 (309) 343-3161, Ext. 210  
**GRANITE CITY**  
**St. Elizabeth Hospital**  
 2100 Madison Avenue  
 (618) 876-2020, Ext. 421  
**HARVEY**  
**Ingalls Memorial Hospital**  
 One Ingalls Drive  
 (312) 333-2300, Ext. 451  
**HIGHLAND**  
**St. Joseph's Hospital**  
 1515 Main Street  
 (618) 654-2171, Ext. 297  
**HIGHLAND PARK**  
**Highland Park Hospital**  
 718 Glenview Avenue  
 (312) 432-8000  
**HINSDALE**  
**Hinsdale San. & Hospital**  
 120 North Oak Street  
 (312) 323-2100, Ext. 336  
**HOOPERSTON**  
**Hooperston Community Memorial Hospital & Nursing Home**  
 701 East Orange Street  
 (217) 283-5531  
**JACKSONVILLE**  
**Passavant Hospital**  
 1600 West Walnut  
 (217) 245-9541  
**JOLIET**  
**St. Joseph Hospital**  
 333 North Madison Street  
 (815) 725-7133, Ext. 679 or 680  
**Silver Cross Hospital**  
 1200 Maple Road  
 (815) 729-7563  
**KANKAKEE**  
**Riverside Hospital**  
 350 North Wall Street  
 (815) 933-1671, Ext. 606  
**St. Mary's Hospital**  
 500 West Court  
 (815) 939-4111, Ext. 735  
**KEWANEE**  
**Kewanee Public Hospital**  
 719 Elliott Street  
 (309) 853-3361, Ext. 219  
**LAKE FOREST**  
**Lake Forest Hospital**  
 660 Westmoreland  
 (312) 234-5600, Ext. 608, 645 or 683  
**LASALLE**  
**St. Mary Hospital**  
 1015 O'Conor Avenue  
 (815) 223-0607, Ext. 14  
**LINCOLN**  
**Abraham Lincoln Memorial Hospital**  
 315 Eighth Street  
 (217) 732-2161, Ext. 346  
**MACOMB**  
**McDonough District Hospital**  
 525 East Grant Street  
 (309) 833-4101  
**MATTOON**  
**Memorial Hospital**  
 2101 Champaign Avenue  
 (217) 234-8881, Ext. 43  
**MAYWOOD**  
**Loyola University Foster G. McGaw Hospital**  
 2160 South 1st Avenue  
 (312) 531-3000, Ext. 3374  
**McHENRY**  
**McHenry Hospital**  
 3516 West Waukegan Road  
 (815) 385-2200, Ext. 614  
**MELROSE PARK**  
**Westlake Community Hospital**  
 1225 Superior Street  
 (312) 681-3000, Ext. 226 or 239  
**MENDOTA**  
**Mendota Community Hospital**  
 Route 51 and Memorial Drive  
 (815) 539-7461, Ext. 225  
**MOLINE**  
**Moline Public Hospital**  
 635-10th Avenue  
 (309) 762-3651, Ext. 232  
**MONMOUTH**  
**Community Memorial Hospital**  
 1000 West Harlem Avenue  
 (309) 734-3141, Ext. 244  
**MOUNT CARMEL**  
**Wabash General Hospital**  
 1418 College Drive  
 (618) 262-4121, Ext. 231

**MOUNT VERNON**  
 Good Samaritan Hospital  
 605 North Twelfth Street  
 (618) 242-4600, Ext. 521

**NAPERVILLE**  
 Edward Hospital  
 South Washington Street  
 (312) 355-0450, Ext. 326

**NORMAL**  
 Brokaw Hospital  
 Virginia at Franklin Avenue  
 (309) 829-7685, Ext. 274

**OAK LAWN**  
 Christ Community Hospital  
 4440 West 95th Street  
 (312) 425-8000, Ext. 385

**OAK PARK**  
 West Suburban Hospital  
 518 N. Austin Boulevard  
 (312) 383-6200

**OLNEY**  
 Richland Memorial Hospital  
 800 East Locust Street  
 (618) 395-2131, Ext. 226

**OTTAWA**  
 Community Hospital of Ottawa  
 1100 E. Norris Drive  
 (815) 433-3100, Ext. 227 or 228

**PARK RIDGE**  
 Lutheran General Hospital  
 1775 Dempster Street  
 (312) 696-5151

**PEKIN**  
 Pekin Memorial Hospital  
 14th & Court Streets  
 (309) 347-1151, Ext. 241

**PEORIA**  
 Methodist Hospital of Central Illinois  
 221 N.E. Glen Oak  
 (309) 685-6511, Ext. 250 or 360

Proctor Community Hospital  
 5409 N. Knoxville Avenue  
 (309) 691-4702, Ext. 791

St. Francis Hospital Medical Center  
 530 N.E. Glen Oak Avenue  
 (309) 672-2109

**PERU**  
 Peoples Hospital  
 925 West Street  
 (815) 223-3300, Ext. 53

**PITTSFIELD**  
 Illini Community Hospital  
 640 West Washington Street  
 (217) 285-2526, Ext. 238

**PRINCETON**  
 Perry Memorial Hospital  
 530 Park Avenue East  
 (815) 875-2811

**QUINCY**  
 Blessing Hospital  
 1005 Broadway  
 (217) 223-5811, Ext. 255

St. Mary Hospital  
 1415 Vermont Street  
 (217) 223-1200, Ext. 275

**ROCKFORD**  
 Rockford Memorial Hospital  
 2400 N. Rockton Avenue  
 (815) 968-6861, Ext. 441

St. Anthony Hospital  
 5666 E. State Street  
 (815) 226-2041

Swedish-American Hospital  
 1316 Charles Street  
 (815) 968-6898, Ext. 635

**ROCK ISLAND**  
 Rock Island Franciscan Hospital  
 2701 17th Street  
 (309) 793-1000, Ext. 2106

**ST. CHARLES**  
 Delnor Hospital  
 975 N. Fifth Avenue  
 (312) 584-3300, Ext. 229

**SCOTT AIR FORCE BASE**  
 USAF Medical Center  
 (618) 256-7595, Ext. 596 or 597

**SPRINGFIELD**  
 Memorial Medical Center  
 First and Miller Streets  
 (217) 528-2041, Ext. 460

St. John's Hospital  
 800 East Carpenter  
 (217) 544-6464, Ext. 210

**SPRING VALLEY**  
 St. Margaret's Hospital  
 600 E. First Street  
 (815) 663-2611, Ext. 464 or 466

**STREATOR**  
 St. Mary's Hospital  
 111 East Spring Street  
 (815) 673-2311, Ext. 221 or 222

**URBANA**  
 Carle Foundation Hospital  
 611 West Park Avenue  
 (217) 337-3100

Mercy Hospital  
 1400 West Park Avenue  
 (217) 337-2131

**WAUKEGAN**  
 St. Therese Hospital  
 2615 West Washington Street  
 (312) 688-6470

Victory Memorial Hospital  
 1324 N. Sheridan Road  
 (312) 688-4181

**WINFIELD**  
 Central DuPage Hospital  
 0 North, 025 Winfield Road  
 (312) 653-6900, Ext. 557

**WOODSTOCK**  
 Memorial Hospital for McHenry County  
 527 W. South Street  
 (815) 338-2500, Ext. 218

**ZION**  
 Zion-Benton Hospital  
 Shiloh Boulevard  
 (312) 872-4561

## LICENSED CLINICAL LABORATORIES

The following is a list of licensed clinical laboratories certified by the Illinois Department of Public Health in states other than Illinois; for a list of Illinois laboratories write IDPH, 1130 South Sixth St., Springfield, IL 62706.

### CALIFORNIA

#### BERKELEY

Solano Laboratories, Inc.  
2920 Telegraph Ave., 94705

#### NEWBURY PARK

Reference Lab., Div. of Abbott Labs.  
1011 Rancho Conejo Blvd., 91320

#### NORTH HOLLYWOOD

Biochemical Procedures, Inc.  
12020 Chandler Blvd., 91607  
Cancer Screening Services  
6440 Coldwater Canyon, 91606

#### SAN DIEGO

Pap Smear Center, Inc.  
4232 University Ave., 92105

#### VAN NUYS

Bio-Science Labs  
7600 Tyrone Ave.

#### WOODLAND HILLS

Lab Procedures—Div. of Upjohn Co.  
6330 Variel Drive, 91364

### FLORIDA

#### OAKLAND PARK

Damon Medical Laboratory  
3290 Northeast 12th Ave., 33308

### INDIANA

#### EVANSVILLE

Mid-America Path. Serv., Inc.  
3700 Belmeade Ave., 47715

#### JEFFERSONVILLE

Physicians Precision Automated Labs  
3408 Industrial Parkway, 47130

### IOWA

#### DAVENPORT

Quad Cities Pathologists Group  
1814 East Locust, 53803

### KANSAS

#### LENEXA

Home Office Reference Lab.  
9900 Pfleum Road, 66215

#### WICHITA

Associated Labs., Inc.  
511 E. 21st St., 67208

### KENTUCKY

#### LOUISVILLE

Clinical Diagnostic Labs., Inc.  
634 South Floyd Street, 40202

### MASSACHUSETTS

#### BOSTON

Clin-Chem Labs., Inc.  
1106 Commonwealth Ave., 02215

### MICHIGAN

#### GRAND RAPIDS

Continental Bio-Cln  
2823 Clydon S.W.

### MINNESOTA

#### ROCHESTER

Mayo Medical Service Ltd.  
200 First St. S.W., 55901

### MISSOURI

#### CLAYTON

Cooper Medical Laboratory  
141 N. Meramic, 63105

#### ST. LOUIS

Allen Medical Labs., Ltd.  
2821 N.Ballas Rd., 63131

Clinical Labs of St. Louis, Inc.  
11636 Administration Dr., 63141

Miller Labs., Inc.

716 Hanley Industrial Ct. Dr., 63144

Midwest Medical Laboratory, Inc.  
4141 Forest Park Blvd., 63108

Missouri Clin. & Biochem Lab.  
4910 Forrest Park Blvd., 63108

Pathology Services  
716 Hanley Industrial Ct. Dr. 63144

### NEW JERSEY

#### HACKENSACK

Metpath, Inc.  
60 Commerce Way, 60606

#### METUCKEN

Center for Lab Medicine  
16 Pearl St., 08840

#### NEWARK

GIB Labs., Inc.  
213 Washington St., 07101

### NORTH CAROLINA

#### BURLINGTON

Biomedical Laboratories, Inc.  
1308 Rainey St., 27215

### OHIO

#### COLUMBUS

Automated Medical Service of Ohio, Inc.  
1466 S. High St., 43207

#### DUBLIN

Consolidated Biomed Labs., Inc.  
6370 Wilcox Road, 43017

#### MANSFIELD

Automated Medical Services of Ohio, Inc.  
666 Park Ave., West, 44906

#### POWELL

Searle Diagnostic, Inc.  
2775 Home Road, 43065

### OREGON

#### PORTLAND

Lancet Laboratories  
2 Plaza S.W., 6900 S.W. Haines Road, 97223

United Medical Labs., Inc.  
10700 N.E. Sandy Blvd., 97220

United Medical Labs., Inc.  
6060 N. 112th, 97208

**SOUTH DAKOTA****SIOUX FALLS**

Lab of Clinical Medicine  
1212 So. Euclid Ave., 57105

**TENNESSEE****MEMPHIS**

Memphis Pathology Lab  
257 S. Bellevue, 38104

**TEXAS****DALLAS**

Bio-Assay Lab., Inc.  
7035 Carpenter Freeway, 75247  
Complete Clinical Lab., Inc.  
3707 Gaston Ave., 75246

**WISCONSIN****MILWAUKEE**

Drug I.D. Laboratory, Inc.  
4608 W. Burleigh St., 53210

**APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS**

Illinois Department of Public Health

Division of Disease Control

Michael Reese Hospital and Medical Center  
29th Street and Ellis Ave., Chicago 60616

Fredric L. Coe, M.D.

Rush-Presbyterian-St. Luke's Medical Center  
1753 West Congress Parkway, Chicago 60612  
Kent Armbruster, M.D.

Washington University Renal Unit  
Chromalloy American Kidney Center  
(Barnes Hospital)  
4949 Barnes Hospital Plaza, St. Louis, Mo. 63110  
Eduardo Slatopolsky, M.D.

The Jewish Hospital of St. Louis  
216 South Kingshighway, St. Louis, Mo. 63110  
Herbert Lubowitz, M.D.

Springfield Medical Center  
First and Miller Sts., Springfield 62701  
Richard Bilinsky, M.D.

Evanston Hospital  
2650 Ridge Ave., Evanston 60201  
Bernard Adelson, M.D.

University Hospitals  
Department of Medicine  
1300 University Ave., Madison, Wis. 53706  
Arvin B. Weinstein, M.D.

University of Illinois Research and Educational  
Hospitals  
840 South Wood St., Chicago 60612  
Franklin Schwartz, M.D.

Mayo Clinic  
Internal Medicine & Nephrology, Rochester, Minn. 55901  
William J. Johnson, M.D.

University of Chicago Hospitals & Clinics  
(Includes LaRabida Sanitarium  
Ronald Kallen, M.D.)  
950 East 59th St., Chicago 60649  
Adrian Katz, M.D.

Mt. Sinai Hospital Medical Center  
Fifteenth and California Aves., Chicago 60608  
Earl C. Smith, M.D.

Northwestern Medical Center  
Passavant Memorial Hospital  
303 East Superior St., Chicago 60611  
Francesco del Greco, M.D.

West Suburban Hospital and West Suburban Kidney  
Center, Inc.

518 North Austin Blvd., Oak Park 60302  
Robert C. Muehrcke, M.D.

Rockford Memorial Hospital  
2300 North Rockton Ave., Rockford 61101  
Ewald T. Sorensen, M.D.

Cook Country Hospital  
1825 West Harrison St., Chicago 60612  
George Dunea, M.D.

St. Francis Hospital  
523 N.E. Glen Oak, Peoria 61603  
Robert Pfleiderer, M.D.

The Children's Memorial Hospital  
2300 Children's Plaza, Chicago 60614  
Peter R. Lewy, M.D.

Lake View Memorial Hospital  
812 North Logan Ave., Danville 61832  
Raja M. Sadiq, M.D.

Mercy Hospital  
1400 West Park Ave., Urbana 61801  
R. E. Tirona, M.D.

St. Joseph Hospital  
2900 North Lake Shore Dr., Chicago 60657  
Gordon Lang, M.D.

Galesburg Cottage Hospital  
674 North Seminary St., Galesburg 61401  
Agha Babanoury, M.D.

Roosevelt Memorial Hospital  
426 West Wisconsin St., Chicago 60614  
Franklin D. Schwartz, M.D.

Ingalls Memorial Hospital  
One Ingalls Drive, Harvey  
Alexander B. White, M.D.

Doctors Memorial Hospital  
404 West Main St., Carbondale 62901  
John Taylor, M.D.

Blessing Hospital  
1005 Broadway, Quincy 62301  
Hugh Espey, M.D.

Jefferson County Memorial Hospital  
909 Shawnee St., Mt. Vernon 62864  
Robert Parks, M.D.

Victory Memorial Hospital  
1324 North Sheridan Rd., Waukegan 60085  
John Freeland, M.D.

Central DuPage Hospital  
0 North 025 Winfield Rd., Winfield 60190  
Paul Balter, M.D.

Loyola University (Foster G. McGaw) Hospital  
2160 South First Ave., Maywood 60153  
A. R. Lavender, M.D.

St. Margaret Hospital  
25 Douglas St., Hammond, Ind. 46320  
James H. Greenwald, M.D.

Edgewater Hospital  
5700 N. Ashland, Chicago 60660  
Gabriel Schwartz, M.D.

St. Elizabeth's Hospital  
211 S. Third St., Belleville 62221  
Joseph Santiago, M.D.

Silver Cross Hospital  
600 Walnut St., Joliet 60432  
Robert S. Markelz, M.D.

Christ Community Hospital  
4440 W. 95th St., Oak Lawn 60453  
Joseph H. Oyama, M.D.

Memorial Hospital of DuPage  
209 Avon Road, Elmhurst 60126  
John Simonaitis, M.D.

Good Samaritan Hospital  
Vincennes, Indiana 47591  
John S. Murray, M.D.

St. Louis Children's Hospital  
500 S. Kingshighway, St. Louis, Mo. 63110  
Alan M. Robson, M.D.

*Dialysis for Veterans with kidney disease is available at:*  
Veterans Administration Hospital, Hines 60141  
A. R. Lavender, M.D.

Veterans Administration Research Hospital, Chicago 60611  
Peter Ivonovich, M.D.

*For further information contact:*

Mrs. Ruth S. Shriner, ACSW—Coordinator Renal Disease  
Program, Illinois Department of Public Health  
Room 150, 535 West Jefferson Street, Springfield 62706  
Phone (217) 782-3303

**Satellites or Limited Care Facilities**

*West Suburban Kidney Center*  
St. Peter's Evangelical Lutheran Church  
500 Hannah, Forest Park 60130

*Lombard Unit*  
First Church of Lombard, Lombard 60148

*Chicagoland Dialysis Center*  
Cathedral Shelter  
Ashland and Adams, Chicago 60607  
Robert C. Muehrcke, M.D.

*University of Illinois Hospitals*

*Dialysis Centers, Limited*  
1200 North LaSalle St., Chicago 60610  
740 N. Rush St., Chicago 60610

*Springfield Medical Center*

St. Mary's Hospital  
1415 Vermont Street, Quincy 62301

*Renal Facility*  
913 N. Rutledge, Springfield 62702

*Alton Memorial Hospital*  
Alton 62002

*Doctors' Park*  
701 North Walnut St., Springfield 62702

*Douglas Nursing Home*  
Mattoon Memorial Hospital, Mattoon 61938

*Decatur Memorial Hospital*  
Decatur 62521

*Norris Hospital*  
Jacksonville 62650

*Evanston Hospital Dialysis Center*

*Niles-Day-Springman Satellite*  
Lawrencewood Shopping Center  
Waukegan Rd., Niles 60648  
Walid Ghantous, M.D.

*North Central Dialysis Centers*

14 East Jackson, Chicago 60610  
Alan Kanter, M.D.

Copley Memorial Hospital  
Lincoln & Weston Avenues  
Aurora

St. Elizabeth's Hospital  
211 S. 3rd Street  
Belleville

Doctors Memorial Hospital  
404 West Main  
Carbondale

Phone: 897-6021  
Person in Charge: M. J. Carbon, M.D.  
Location in Hosp: Intermediate Care

Phone: 234-2120  
Person in Charge: Joseph Santiago, M.D.  
Sister Jamesine Lamb, R.N.  
Location in Hosp: Hemodialysis Unit

Phone: 549-0721  
Person in Charge: Sam Namminga, M.D.  
Location in Hosp: Renal Dialysis

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|--|--|---|
| Children's Memorial Hospital<br>2300 Children's Plaza<br>Chicago                           | Phone: 649-4000<br>Person in Charge:<br>Location in Hosp:  | Peter Lewy, M.D.<br>Nephrology  |
| Cook County Hospital<br>1825 West Harrison<br>Chicago                                      | Phone: 633-6000<br>Person in Charge:<br>Location in Hosp:  | George Dunea, M.D.<br>Renal   |
| Edgewater Hospital<br>5700 N. Ashland Avenue<br>Chicago                                    | Phone: 878-6000<br>Person in Charge:<br>Location in Hosp:  | Gabriel Schwartz, M.D.<br>Surgery   |
| La Rabida Children's Hospital & Research Center<br>E. 65th St. at Lake Michigan<br>Chicago | Phone: 363-6700<br>Person in Charge:<br>Location in Hosp:  | Dr. Ronald J. Kallen<br>Hemodialysis Unit, 2nd Floor                      |
| Mercy Hospital & Medical Center<br>Stevenson Expressway at King Drive<br>Chicago           | Phone: 567-2390<br>Person in Charge:<br>Location in Hosp:  | Carlos Otero, M.D.<br>Medicine Dept.                                      |
| Michael Reese Hosp. & Medical Center<br>2900 S. Ellis<br>Chicago                           | Phone: 791-3400<br>Person in Charge:<br>Location in Hosp:  | or 791-3395<br>Mr. Willis Hill<br>Dialysis Section Dept.                  |
| Mt. Sinai Hospital Medical Center of Chicago<br>15th & California Avenue<br>Chicago        | Phone: 542-2505<br>Person in Charge:<br>Location in Hosp:  | Earl Smith, M.D.<br>Medicine Dept.  |
| Northwest Hospital Inc.<br>5645 W. Addison St.<br>Chicago                                  | Phone: 282-7000<br>Person in Charge:<br>Location in Hosp:  | Jayme Neuman, M.D.<br>Intensive Care                                      |
| Northwestern Memorial Hospital<br>Superior & Fairbanks Court<br>Chicago                    | Phone: 649-2000<br>Person in Charge:<br>Location in Hosp:  | Francesco delGreco, M.D.<br>Dialysis Dept.                                |
| Rush-Presbyterian-St. Luke's<br>1753 West Congress Parkway<br>Chicago                      | Phone: 942-5000<br>Person in Charge:<br>Location in Hosp:  | Todd Ing, M.D.<br>Renal Dialysis  |
| Ravenswood Hospital Medical Center<br>4550 N. Winchester<br>Chicago                        | Phone: 878-4300<br>Person in Charge:<br>Location in Hosp:  | Norbert Nadler, M.D.<br>Nursing Unit, 5-West                              |
| Roosevelt Memorial Hospital<br>426 W. Wisconsin<br>Chicago                                 | Phone: 664-8000<br>Person in Charge:<br>Location in Hosp:  | Franklin Schwartz, M.D.<br>Intensive Care, 3rd Floor                      |
| St. Joseph Hospital<br>2900 N. Lake Shore Drive<br>Chicago                                 | Phone: 528-1000<br>Person in Charge:<br>Location in Hosp:  | Franklin Schwartz, M.D.<br>Nephrology & Renal Dialysis                    |
| University of Chicago Hospital & Clinics<br>950 E. 59th<br>Chicago                         | Phone: 947-5797<br>Person in Charge:<br>Location in Hosp:  | Adrian Katz, M.D.<br>Kidney Dialysis Lab.                                 |
| University of Illinois Hospital<br>840 S. Wood St.<br>Chicago                              | Phone: 996-7000<br>Person in Charge:<br>Location in Hosp:  | Luis F. Gutierrez, M.D.<br>Medicine/Nephrology<br>or Kidney Unit 443-5318 |
| Lake View Memorial Hospital<br>812 N. Logan Avenue<br>Danville                             | Phone: 443-5000<br>Person in Charge:<br>Location in Hosp:  | Sharon Tuggle, R.N.<br>Intensive Care & Hemodialysis Unit                 |
| St. Joseph Hospital<br>77 Airlite<br>Elgin   | Phone: 695-3200,<br>Person in Charge:<br>Location in Hosp: | ext. 348<br>Wm. T. Sheehy, M.D.<br>Emergency Dept.<br>Mr. Gerald Pearson  |
| Sherman Hospital<br>934 Center Street<br>Elgin   | Phone: 742-9800<br>Person in Charge:<br>Location in Hosp:  | A. Hassan Khazei, M.D.<br>Surgery   |

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| Memorial Hospital of DuPage Co.<br>209 Avon Road<br>Elmhurst                               | Phone: 833-1400<br>Person in Charge:<br>Location in Hosp:  | J. J. Simonaitis, M.D.<br>Dept. of Medicine                          |
| Evanston Hospital<br>2650 Ridge Avenue<br>Evanston   | Phone: 492-6815<br>Person in Charge:<br>Location in Hosp:  | Dorothy Welch, R.N.<br>Hemodialysis                                  |
| St. Francis Hospital of Evanston<br>355 Ridge Avenue<br>Evanston                           | Phone: 492-4000<br>Person in Charge:<br>Location in Hosp:  | Dongsuk Kim, M.D.<br>Nursing   |
| Galesburg Cottage Hospital<br>695 N. Kellogg<br>Galesburg                                  | Phone: 343-4121,<br>Person in Charge:<br>Location in Hosp: | ext. 230<br>Carol Weber, R.N.<br>Hemodialysis Unit                   |
| Ingalls Memorial Hospital<br>One Ingalls Drive<br>Harvey                                   | Phone: 333-2300<br>Person in Charge:<br>Location in Hosp:  | Norman R. Brill, M.D.<br>Renal Dialysis                              |
| Silver Cross Hospital<br>1200 Maple Road<br>Joliet   | Phone: 729-7111<br>Person in Charge:<br>Location in Hosp:  | R. A. Markelz, M.D.<br>Special Care Floor<br>Building #2, Floor #2   |
| Foster G. McGaw Hosp. of Loyola University<br>2160 South 1st Avenue<br>Maywood             | Phone: 531-3000<br>Person in Charge:<br>Location in Hosp:  | Edwina Franand<br>Renal Dialysis                                     |
| Jefferson Memorial Hospital<br>909 Shawnee<br>Mt. Vernon                                   | Phone: 242-3400<br>Person in Charge:<br>Location in Hosp:  | Barbara Cailteux, R.N.<br>Robert Parks, M.D.<br>Kidney Dialysis Unit |
| West Suburban Hospital<br>518 N. Austin Blvd.<br>Oak Park                                  | Phone: 383-6200<br>Person in Charge:<br>Location in Hosp:  | ext. 6587<br>Robert Muehrcke, M.D.<br>Kidney Dialysis Center         |
| Christ Community Hospital<br>4440 West 95th St.<br>Oak Lawn                                | Phone: 425-8000<br>Person in Charge:<br>Location in Hosp:  | Joseph Oyama, M.D.<br>Physical Therapy & Rehab.                      |
| Methodist Hospital of Central Illinois<br>221 N.E. Glen Oak Ave.<br>Peoria, Illinois 61603 | Phone: 685-6511<br>Person in Charge:<br>Location in Hosp:  | Miss M. Fritz, R.N.<br>J. Meyers, M.D.<br>Intensive Care Unit        |
| St. Francis Hospital<br>530 N.E. Glen Oak<br>Peoria  | Phone: 672-2000<br>Person in Charge:<br>Location in Hosp:  | R. A. Pfiederer, M.D.<br>Hemodialysis                                |
| Blessing Hospital<br>1005 Broadway<br>Quincy   | Phone: 223-5811<br>Person in Charge:<br>Location in Hosp:  | Mrs. Marian Almasy, R.N.<br>Hugh Espay, M.D.<br>Renal Dialysis       |
| Rockford Memorial Hospital<br>2400 N. Rockton Ave.<br>Rockford                             | Phone: 968-6861<br>Person in Charge:<br>Location in Hosp:  | E. T. Sorensen, M.D.<br>Dept. of Medicine                            |
| Memorial Medical Center<br>1st & Miller<br>Springfield                                     | Phone: 528-2041<br>Person in Charge:<br>Location in Hosp:  | Dr. Richard Bilinsky<br>7th Floor                                    |

Mercy Hospital  
1400 West Park  
Urbana

Phone: 337-2233  
Person in Charge: R. F. Tirona, M.D.  
Location in Hosp: Mr. Michael Luth  
Nursing Service

Victory Memorial Hospital  
1324 North Sheridan Road  
Waukegan

Phone: 688-3000  
Person in Charge: John P. Freeland, M.D.  
Location in Hosp: Dialysis Unit

Central DuPage Hospital  
0 N 025 Winfield Road  
Winfield

Phone: 653-6900  
Person in Charge: P. Balter, M.D.  
Location in Hosp: Kidney Dialysis

*In addition to the hospitals in Illinois, we have also received information that the following hospital has an artificial kidney. This out of state hospital may be more accessible in some emergencies than those in Illinois:*

Barnes Hospital  
4949 Barnes Hospital Plaza  
St. Louis, Missouri

Phone: 367-6400  
Person in Charge: Dr. Edwardo Slatapolsky  
Location in Hosp: Renal Division

## Medical Legal Information

(Prepared by ISMS Legal Counsel, James L. Fletcher)

*The purpose of this article is to present the Illinois medical community with a general view of certain medical-legal principles and relationships which many physicians may encounter in the ordinary practice of their profession. Because this article is intended to provide information of a general nature only, specific problems should be discussed with one's individual attorney. While this presentation is not all-inclusive, it will afford an insight into the more common considerations.*

### ISMS LEGAL SERVICES

The Illinois State Medical Society retains, on a continuing basis, a general counsel to whom the Society refers legal questions affecting the membership as a whole. ISMS also answers specific inquiries made by the component county medical societies when they are of general interest to the medical community. Although

the Illinois State Medical Society cannot provide personal legal advice to individual members, the Society does believe the following information will help further each physician's awareness of certain basic legal principles and concepts vital to his practice.

### THE PHYSICIAN-PATIENT RELATIONSHIP

#### *Contractual Relationship*

In most instances the physician-patient relationship is a voluntary, contractual one. Accordingly, physicians are required to accept only those patients they elect to treat. The professional services rendered on behalf of particular patients and the fees compensating the physician for those services are to be decided by the physician and the patient.

Whenever possible, the physician should discuss his fee with the patient in advance of treatment. If feasible, the understanding as to the fee should be reduced to writing as a permanent record for both parties. Not only does such a procedure minimize misunderstanding, but it may help to re-emphasize to the patient, and his carrier, the specific contractual duties that the patient has undertaken. In the absence of a specific fee agreement, a physician is entitled to "reasonable compensation" for services rendered by him.

While, as has been indicated above, a physician is free to determine who will be his patients, once the physician has undertaken the treatment of a particular patient, he is under a legal duty, subject to certain exceptions discussed below, to continue his attendance so

long as the case requires attention. To disregard this duty may constitute negligence or malpractice on the part of the physician.

A physician may legally terminate his attendance of a particular case in several ways:

1. The contract between the physician and the patient expressly limits the scope of treatment;
2. The patient may discharge the physician;
3. The relationship may end by mutual consent;
4. The physician may legally terminate his services if the patient breaks the contract by failing to observe the medical directives of the physician.

In the event the patient fails to follow the physician's advice, the duties of the attending physician do not immediately terminate. Rather, the attending physician must provide the patient with sufficient, reasonable notice of his intention to withdraw, so as to enable the patient to secure another physician. This notice should be in writing and briefly explain to the patient the reason for the intended termination. If the patient returns to the attending physician, and has been unable to procure other medical assistance, the attending physician should *not* refuse continued treatment until a replacement has been secured.

## HOSPITAL PATIENT RECORDS

Illinois law provides that every public and private hospital in the State shall, upon the written demand of any discharged patient, permit that patient's physi-

cian or authorized attorney to examine and make copies of his hospital records. These disclosure provisions do not apply in the case of a psychiatrist-patient relationship.

## NEGLIGENCE LIABILITY OF PHYSICIANS

Illinois law requires physicians and surgeons to exercise that degree of reasonable skill as is used in ordinary good practice. The failure to exercise such skill will result in liability if the patient is thereby injured.

Recently, there has been a tendency (especially in the larger cities) to expand liability and to increase the amounts of recovery once liability has been established. When a sympathetic jury views an injured patient, it may well be inclined to interpret the facts in a manner detrimental to the physician. Although the "reasonable skill" standard is not unduly harsh, it is flexible enough to make its application in a particular lawsuit quite subjective.

While the legal implications in the field of malpractice litigation are numerous in scope, basically, the physician is liable for his own negligent acts and the negligent acts of all his employees. In the case of a partnership, he is also liable for the negligent acts of his partners.

Today there is simply no existing alternative to carrying adequate liability insurance. While the cost of various types of malpractice insurance coverage is costly and still increasing, it is nonetheless recommended that extremely high limits be maintained in one's policy.

In addition to purchase of malpractice insurance, each physician should attempt to conduct his practice in such a fashion that the initiation of (and the finding of "guilty" verdicts in) malpractice litigation is greatly minimized.

The American Medical Association has published and prepared for distribution a pamphlet entitled "Professional Liability and the Physician." Twenty guidelines for preventing malpractice actions are set forth in that pamphlet:

1. The physician must care for every patient with scrupulous attention given to the requirements of good medical practice.

2. The physician must know and exercise his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician must keep records which clearly show what was done and when it was done, which clearly indicate that nothing was neglected, and which demonstrate that the care given met fully the standards demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.

5. A physician must avoid making any statement which constitutes, or might be construed as constituting, an admission of fault on his part. He should instruct employees to make no such statements.

6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.

7. The physician must refrain from over-optimistic prognoses.

8. The physician must advise his patients of any intended absences from practice and recommend, or make available, a qualified substitute. The patient must not be abandoned.

9. The physician must unfailingly secure an "informed" consent (preferably in writing) for medical and surgical procedures and for autopsy.

10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.

11. The physician should limit his practice to those fields which are well within his qualifications.

12. The physician must frequently check the condition of his equipment and make use of every available safety installation.

13. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment.

14. The physician must realize that it is dangerous to diagnose or prescribe by telephone.

15. The physician should not sterilize a patient solely for the patient's convenience, except after a reasonably complete explanation of the procedure and its risks and possible complications; and after obtaining a signed consent from the patient and from the patient's spouse, if the patient is married. Such sterilization is a crime in Connecticut, Kansas, and Utah and should not be performed in those states. Eugenic sterilization should be performed only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may lawfully be performed with the informed consent of the patient and preferably with the informed consent of the patient's spouse, if the patient is married.

16. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.

17. The physician should exhaust all reasonable methods of securing diagnosis before embarking upon a therapeutic course.

18. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.

19. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes and, in addition, should ascertain the customary dosage or usage in his area.

20. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

In the October, 1971, issue of the *Illinois Medical Journal*, legal counsel to the Illinois State Medical Society expanded upon the recommendations of the AMA and urged that Illinois physicians also observe the following preventative safeguards:

1. Physicians should conduct their practice in hospitals so that they comply with, and live up to, the standards for hospital accreditation of the American Hospital Association, the hospital regulations adopted by the

State Department of Public Health under the Hospital Licensing Act, and the by-laws of the hospital in which they are practicing.

2. Physicians should keep up on modern medicine in the fields in which they practice so they are conversant with and use the latest proven developments.

3. Physicians should call in specialists whenever the need arises.

4. Physicians should provide for automatic consultation in all serious cases—it cannot be disputed that any physician being called on to defend his treatment in court is in a much better position if he can also bring forth as a witness the physician who reviewed the case and consulted with him, or the specialist in a given

field called in by him.

5. Hospital records and those of the physician should be kept in such manner and in such detail as will be meaningful and show that adequate medical procedures were followed. It should be remembered that cases frequently are not filed until some time after the alleged injury took place and sometimes do not come to trial for several years thereafter.

6. All cases should be treated in such a manner and records kept as if the case would result in a malpractice suit, and would not come to trial for a considerable period of time after the alleged injury had taken place.

7. Physicians should carry adequate malpractice insurance.

## ILLINOIS CONTROLLED SUBSTANCES ACT

Under the Illinois Controlled Substances Act, physicians who dispense various controlled substances are required to register with the Illinois Department of Registration

and Education. Categories of drugs under which registration is required are almost identical to those already established by the Federal DEA.

## LIMITS ON LIABILITY—SPECIAL SITUATIONS

Under the "Good Samaritan" amendment to the Medical Practice Act, physicians who, in good faith and without prior notice of the illness or injury, provide emergency care without fee to a person, shall not, as a result of acts or omissions, except wilful or wanton misconduct, be liable for civil damages.

The Medical Practice Act further provides that any physician, serving on any medical utilization committee, medical review committee, or peer review committee shall not be liable for civil damages as a result of his acts, or omissions, or decisions in connection with his duties on such committee, except those acts, omissions or decisions which involve wilful or wanton misconduct.

## AUTOPSY

The *Illinois Revised Statutes* specifically detail the conditions under which a physician may perform an autopsy. Essentially, an autopsy may be performed provided:

1. The physician has a written authorization from the decedent to do so; or
2. The physician has a written authorization from a surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right (a "surviving relative" means the spouse, an adult child, the parent, or an adult brother or sister of the decedent); or
3. The physician has a telegraphic or telephonic authorization from a surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right. This last provision is conditioned, however, upon the requirement that the telegraphic or telephonic authorization is verified, in writing, by at least two persons who were present at the time and place the authorization was received.

Illinois law specifically provides that where two or more persons have equal right to determine the method for disposing of the body, the authorization of only one such

person shall be necessary, unless, before the autopsy is performed, any others having such equal right shall object in writing or, if not physically present in the community where the autopsy is to be performed, by telephonic or telegraphic communication to the physician by whom the autopsy is to be performed.

While authorization may be given to a physician or hospital administrator or his duly authorized representative, only a physician shall perform the autopsy. The authorized personnel of a hospital or other qualified personnel selected by a physician may assist a physician performing an autopsy.

The term "written authorization", provided for above, means any printed, typed or handwritten communication signed by the person granting the authorization.

It is important to emphasize that, in Illinois, the heirs and next of kin can bring an action for mutilation of the body of a decedent in those cases in which an autopsy is performed without authority or permission. In order to avoid the possibility of liability, autopsies should only be performed when ordered by the coroner or upon the appropriate written consent of the next of kin as specified above. (The coroner may order an autopsy directly against the wishes of the next of kin).

## CONSENT OF MINORS TO MEDICAL TREATMENT

**Birth Control Services for Minors:** Birth control services and information may be rendered by doctors licensed in Illinois to practice medicine in all of its branches to any minor: who is married; who is a parent; who is pregnant; who has the consent of his parent or legal guardian; as to whom the failure to provide such services

would create a serious health hazard; or who is referred for such services by a physician, clergyman or a planned parenthood agency.

**Venereal Disease and Drug Use—Consent to Treatment By Minor:** Illinois law specifically provides that a minor, 12 years of age or older, who may have come into

contact with any venereal disease or who is suffering from the use of depressant or stimulant drugs or narcotic drugs (as defined in Controlled Substances Acts), may give his or her own binding consent, which is not later voidable, to the furnishing of medical care or counselling related to the diagnosis or treatment of such disease. Each incident of venereal disease shall be reported to the State Department of Public Health or the local board of health in accordance with regulations that may be so adopted. Illinois law specifically states that the consent of the parent,

parents, or guardian of such minor, receiving such treatment or counselling, shall not be necessary to authorize the care or counselling which is related to the diagnosis or treatment of such disease or drug or narcotic use.

Any physician who provides diagnosis or treatment to a minor patient who has come into contact with any venereal disease or suffers from the use of any drug or narcotic, referred to above, may, but shall not be obligated to, inform the parent, parents or legal guardian of any such minor as to the treatment given or needed.

## CATEGORIES OF MINORS WHO MAY, BY LAW, GIVE CONSENT TO ANY AND ALL MEDICAL TREATMENT

**Parental Consent for Treatment of a Minor Child**  
**When Parent is Also a Minor:** Illinois law provides that a parent who is a minor may give his or her consent to the performance upon his or her child of a medical or surgical procedure by a physician licensed to practice medicine and surgery or a dental procedure by a licensed dentist. The consent of such parent is not voidable because of his or her minority and Illinois law specifically provides that this parent, who is a minor, is deemed to have the same legal capacity to act and shall have the same powers and obligations as has a person of legal age.

"The consent to the performance of a medical or surgical procedure, by a physician licensed to practice medicine and surgery, which is executed by a married person who is a minor or by a pregnant woman who is a minor is not

voidable because of such minority and Illinois law further provides that such married person, who is a minor, or such pregnant woman, who is a minor, is deemed to have the same legal capacity to act and has the same powers and obligations as has a person of legal age."

**Situations Where Consent Need Not Be Obtained For Treatment of a Minor:** Whenever a hospital or a physician renders emergency treatment or first aid (or a licensed dentist renders emergency dental treatment) to a minor, consent of the minor's parent or legal guardian need not be obtained if, in the sole opinion of the physician, dentist or hospital, the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of such minor's health.

## UNEMPLOYMENT COMPENSATION

The Illinois Unemployment Compensation law has recently been expanded so that it now includes coverage by physicians who employ only one person. This liability was discussed at some length in the "Practice Management" section of the July, 1973, issue of the *Illinois*

*Medical Journal*. If physicians have specific questions regarding the applicability of unemployment compensation to their employees, they should consult the Illinois Department of Labor, Division of Unemployment Compensation, or their attorney.

## BLOOD LABELING

The Illinois Blood Labeling Act contains three requirements of particular importance to the medical profession:

1. No person may administer blood by transfusion in Illinois unless the container of such blood is labeled in conformity with regulations developed and specified by the Illinois Department of Public Health;

2. When blood is administered by transfusion in Illinois, the identification number of the unit of blood must be recorded in the patient's medical record and the label on the container of blood may not be removed before or during the administration of that blood by transfusion;

3. As of July 1, 1973, no blood (which has been initially acquired by purchase) may be administered by transfusion in Illinois unless:

- a. The physician in charge of the treatment of the patient to whom the blood is to be administered has directed that such purchased blood be administered to that patient; and
- b. The physician in charge of the treatment of the patient has specified in the patient's medical record his reason for such action.

## IMMUNIZATION

In 1972, legislation was passed to eliminate the requirement of smallpox immunization and to add rubella to the list of diseases against which there must be immunization.

The 1973 session of the Illinois General Assembly, however, eliminated a listing of specific diseases against which

there must be immunization and transferred responsibility for determination of these to the Illinois Department of Public Health. Thus, the director will promulgate regulations, which may change from time to time, as to which diseases children will be immunized against. This affects the School Code and the Communicable Disease Act.

## MEDICAL CORPORATIONS

Until 1963, when the Illinois General Assembly passed the Medical Corporation Act, physicians were not able to avail themselves of the legal advantages of doing busi-

ness as a corporation. Historically, a primary reason for forbidding the use of the corporate form for doctors was that the personal assets of a corporation's stockholders

were traditionally beyond the reach of creditors, including persons injured by the agents of the corporation. Because the public wished to insure itself of the best medical care, the law would not permit doctors to insulate themselves from personal malpractice liability.

The corporate form did, however, present certain advantages, particularly in the area of taxation, for which there was no compelling reason to discriminate against professionals. Throughout the past two decades the tax status of various professional medical corporations were thrashed out among the Internal Revenue Service, the Federal courts and professionals who claimed that their businesses were entitled to be taxed as corporations. Although many legal questions still remain unresolved, it is now reasonably certain that physicians in Illinois can take advantage of the corporate form.

Under the Illinois law, all the shareholders, officers and directors of a medical corporation must be licensed physicians. The corporation must register with the Illinois Department of Registration and Education under whose auspices it is permitted to operate. This law explicitly denies physicians working within a corporation the right to insulate their personal assets from malpractice liability.

Tax consequences are the primary factors in determining the wisdom of incorporation. In an article written for the November, 1970, issue of the *Illinois Bar Journal* Linscott R. Hanson summarized the advantages and disadvantages of incorporation. Among the major *advantages* listed, were:

1. Deductability by employees of a portion of their sick pay.
2. Deductability as a corporate business expense of the

full cost of employee accident and health insurance.

3. Deductability as a corporate business expense of medical payments in excess of insurance.

4. Lower corporate tax rates for funds to be re-invested in the business.

5. Relatively easy adjustment of ownership percentages.

6. Avoidance of many probate problems upon the death of a practitioner and the avoidance of having to create a whole new business as when a partner dies.

7. Liability limitation, other than for malpractice, to the investment in the corporation thus reducing investors' risks.

8. Miscellaneous pension and profit-sharing tax advantages.

The disadvantages listed by Hanson included:

1. Possible legal costs in defending, to the Internal Revenue Service, the corporate status.

2. An increase of up to 25% for Social Security costs.

3. Corporate franchise taxes.

4. Possible subjection in fact to capital stock and personal property taxes.

5. Increased administrative and legal costs.

6. Increased state income tax payments.

7. State licensing fees.

8. Subjection to a host of State and Federal regulations of corporations.

Certainly each practitioner, physician and partnership should consider the merits of incorporating. The purpose here has been to give a brief explanation so that each interested physician can receive a general over-view of his options. A tax specialist should, of course, be consulted to review the particulars of each business situation.

## MDs EXCLUDED FROM 'CERTIFICATE OF NEED' CONTROLS

Plan to build, expand, move or sell a hospital, nursing home or surgicenter will require approval of the State Comprehensive Health Planning (CHP) Agency under S.B. 1609 which has been signed into law.

A provision in the original bill which would have brought physicians' offices and clinics under "certificate of need" regulation was withdrawn because of vigorous ISMS opposition.

The new law covers construction or modification plans involving an expenditure of more than \$100,000, or a substantial change in services or bed capacity. In effect, facilities covered by the "certificate of need" umbrella will be shifted into a semi-public utility status.

Under S.B. 1609, local CHP agencies will hold public hearings on all applications for construction or expansion before submitting a recommendation to the state CHP board for final action. The State CHP agency will be required to study: (1) area size; (2) population and growth potential; (3) number of existing and planned facilities offering similar services; (4) utilization of existing facilities and (5) availability of alternative facilities and services before granting approval.

Physicians can play a significant role in the decision-making process through involvement with local CHP agency committees, and by participating in public hearings held to review applications.

## REGULATE HMO DEVELOPMENT, SERVICES

A nine-member Health Maintenance Advisory Board within the Illinois Department of Public Health (IDPH) will develop standards governing the quality of services provided by Health Maintenance Organizations (HMOs).

Under S.B. 1128, IDPH also will evaluate an HMO

applicant's ability to meet these standards and refer its findings to the Illinois Department of Insurance which grants HMO certification. In addition, IDPH is required to conduct annual reviews of HMO services.

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# Repeal of the Aurora Brand Interchange Agreement

BY H. MICHAEL WILD, EXECUTIVE DIRECTOR, KANE COUNTY MEDICAL SOCIETY

With no significant evidence that patients were saving money on prescription medicine purchases, and due to abuses, the Southern and Middle branches of the Kane County Medical Society (KCMS) terminated a brand interchange agreement with the Aurora Area Pharmaceutical Association (AAPhA).

The agreement, which was in effect for nearly 15 months, allowed pharmacists to substitute medicines according to a nine-category formulary without consulting prescribing physicians. This could be accomplished unless the physician indicated to the contrary.

While there was a general absence of patient savings, a prescription survey also revealed that some pharmacists were substituting medicines where not authorized; dispensed medicines not included in the formulary; and improperly labeled prescription vials to misrepresent the actual medicine that was dispensed.

Prescription-drug substitution programs, such as this agreement, are favored by some consumer groups, pharmacy associations, and various other organizations as a method to save money for the patient. However, experience in the Aurora area clearly illustrates that this money-saving intent was not realized in practice. (Similar programs elsewhere in the United States and a provincial program in Canada also have failed to generate savings for the patient.)

The Aurora area interchange agreement was initiated by the APhA. A major step towards its implementation was establishment of a "therapeutics committee." This committee of three physicians and three pharmacists drew up a basic formulary. Seven of the nine categories were: ampicillin, erythromycin (base, stearate, and ethyl succinate), erythromycin estolate, penicillin G, penicillin VK, tetracycline HCl, and tetracycline phosphate complex (all antibiotics). Only one product was included in the erythromycin estolate and tetracycline phosphate complex categories. The other two formulary categories were hydrochlorothiazide and meprobamate. Only medicines from well-known manufacturers were included in the formulary categories (choices ranging between three and ten

products per category), thus eliminating blanket generic interchange.

After development of the formulary, the APhA sought agreement for the interchange with the 177 physicians who are members of the Southern and Middle branches of the KCMS. A cover letter to the physicians described the intent of the interchange: ". . . to serve public health and welfare by prescribing and dispensing high quality drugs and biologicals at the lowest possible cost." Also enclosed were the formulary and a form for physicians to sign indicating whether they chose to participate in the agreement.

Eighty-eight replies from physicians were received by the APhA, with 86 physicians favoring the agreement. The two remaining respondents did not wish to participate. However, more than 50% did not reply at all, and it might be assumed that they were not in favor of the brand interchange program even with a limited number of formulary categories.

The interchange agreement was endorsed in principle during a regular meeting of the Southern Branch of the KCMS. About 100 physicians are members, with about 30 regularly attending the monthly meetings.

Many pharmacists in Aurora and the neighboring communities of Batavia, Geneva, and St. Charles apparently assumed that interchanges could be made for prescriptions from all physicians in the Southern and Middle branches since a majority of the respondents (but not a majority of the membership) favored the agreement.

One of the first effects of the interchange was noticed by the patient of a physician who had not agreed to the interchange. Because this patient had experienced diarrhea from ampicillin, the physician prescribed hetacillin (converted by the body to ampicillin) to avoid the diarrhea in the patient. The pharmacist substituted ampicillin in filling the prescription, even though hetacillin did not appear on the formulary.

A psychiatrist later reported that several patients expressed anxiety about changes in their medication. Psychotropic drugs of a different size, dosage form, shape, or color had been dispensed:

hardly an assuring situation for psychiatric patients. This new medication, the patients thought, indicated their conditions were worsening. In addition, this physician had requested to be notified in writing each time an interchange was made. This was never done.

Alarmed by results of the interchange, the psychiatrist conducted a small-scale survey of prescriptions and found that unauthorized substitution was prevalent, and that savings were seldom, if ever, being passed to the patient.

### Review of Experience

After a year's experience with the agreement, members of the Southern Branch began to question its value. At a regular monthly meeting, several physicians reported they had asked patients to return to their offices with prescription vials to confirm the drug dispensed and its price.

After this meeting, the KCMS conducted a prescription survey to better learn how the interchange was being handled by pharmacists. Three physicians (two who had agreed to the interchange and one who did not) wrote a total of 36 prescriptions for use in the survey. The prescriptions were filled at eight pharmacies representing a cross-section of the stores in the area: large and small chains, large and small independent stores, and downtown and suburban locations.

In total, the 36 prescriptions revealed 26 failures to conform to the terms of the agreement. Multiple failures were found for some of the prescriptions, while no violations were noted in the dispensing and pricing of other prescriptions. The appropriate prescription vials were returned to each of the three physicians for his verification of the results.

The 26 failures to conform to the agreement were:

- 13 occasions—no apparent savings for the patient
- 5 occasions—prescription vial mislabeled
- 4 occasions—unauthorized interchange
- 4 occasions—dispensed medicine not on formulary.

In one case, each type of failure was recorded for a single prescription. A lower-cost, non-formulary antibiotic was dispensed for the same

price as the most costly chemical equivalent, with the prescription label carrying the name of the most costly brand. In addition, the physician who wrote the prescription was not a participant in the interchange agreement.

The survey also revealed that certain pharmacists were openly substituting beyond the limitations of the formulary, while other pharmacists did not substitute at all, even where savings may have been possible.

Results of the survey were presented at the next meeting of the Southern Branch. After discussion, a floor motion to terminate the interchange was unanimously approved by those in attendance.

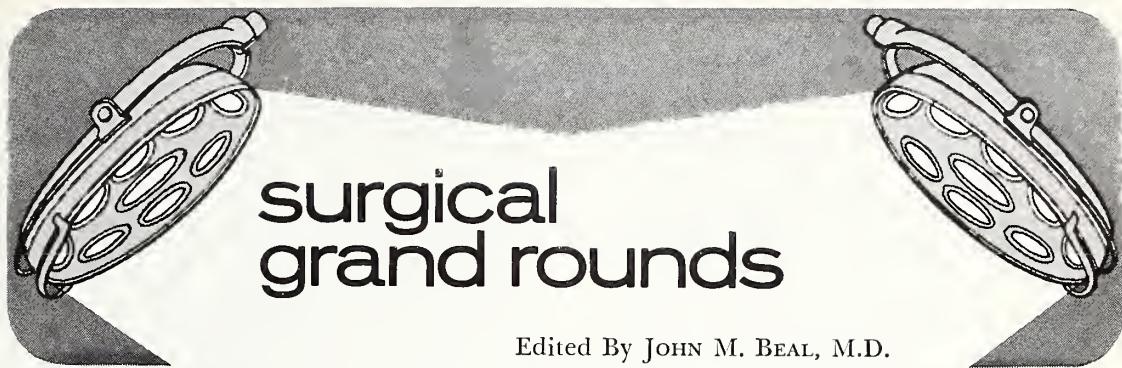
In a letter to the president of the APhA, the president of the Southern Branch terminated the interchange agreement. The letter stated in part: "Our decision to terminate the agreement was based on the growing number of violations brought to our attention during the last few months." Copies of the letter also were sent to all pharmacies in the Aurora area.

**COMMENT:** The brand interchange agreement was given a fair trial over 15 months. In general, the agreement did not provide the intended savings for patients. Certain pharmacies took advantage of the interchange by substituting lower-cost medicines and not passing the savings on to the patient. Interchange of certain products caused patient anxiety in several instances and an adverse reaction for another patient. There was unauthorized interchange and mislabeling. Professional relationships among physicians and pharmacists undoubtedly suffered because of the agreement.

Small, limited substitution agreements such as this are a part of the American Pharmaceutical Association's strategy in its push for repeal of present state-wide anti-substitution laws. If the experiences during the Aurora interchange agreement are typical, repeal of anti-substitution laws would be ill-advised.

If any drug interchange or substitution system would have a chance of working, this would be the way to do it—locally.

It is apparent that the patient was not well served by brand interchange in the Aurora area. ▶



## surgical grand rounds

Edited By JOHN M. BEAL, M.D.

# Stroke in a 19 Year-Old Man

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of February 5, 1974.*

**Dr. Ralph Otto:** A 19-year-old white male college student was admitted for investigation because of four episodes of syncope. The first episode occurred in November 1971. Following a period of weight lifting, he became nauseated, dizzy and fell to the floor. He said he did not lose consciousness and after several minutes could get up and move around. The second episode occurred in the summer of 1972. Again, the patient fell but did not lose consciousness. He noted some amnesia for the events surrounding the event, but experienced a full recovery. He had a third episode in December of 1972 which was followed by transient right hemiparesis. This episode was preceded, like the others, with light headedness, dizziness, tinnitus, but without loss of consciousness. He was admitted to another hospital. He was found to have a right-sided neurological deficit which improved during the period of observation. The study included electroencephalography, lumbar puncture and angiography which were reported to be normal. He was given Dilantin and apparently was well until December of 1973. Again, he noted light headedness, tinnitus and marked weakness. He slumped over his desk, but after several minutes he could walk with assistance. Other past history was not significant.

Physical examination was unremarkable. Mur-

murs or bruits were not present over the carotid arteries and the lungs were clear. An intermittent diastolic murmur was detected at the apex of the heart by some observers. Abdominal examination was unremarkable. Neurological examination at this time was essentially normal, except for mild ataxia and slowness in speech. Admission laboratory data were within normal limits including protein electrophoresis. An electroencephalogram was negative. Cerebral arteriography was performed.

**Dr. Peter Weinberg:** This is a most interesting case and one that demonstrates the importance of obtaining evaluation of the total cerebral circulation. The medical history on this patient certainly suggests that there is involvement of both the right and left cerebral hemispheres as well as involvement of the vertebral basilar system. For this reason, we elected to perform a retrograde femoral catheter study and to selectively inject the contrast material into both the right and left carotid arteries as well as into the vertebral artery. The injection demonstrated the excellent filling of all of the posterior fossa vessels that usually results from an injection of contrast material into one of the vertebral arteries and in this case, the left vertebral vessel. This study demonstrated the presence of a fusiform aneurysm involving the proximal portion of the left

superior cerebellar artery as this vessel is coursing around the proximal pons.

The largest of the aneurysms was in the posterior fossa and there were also other smaller spherical aneurysms involving the distal right anterior-inferior cerebellar artery as this vessel loops over the flocculus of the cerebellum, another involving the distal parietal and occipital branches of both posterior cerebral arteries as well as the posterior temporal branch of the left posterior cerebral artery. All of these aneurysms are readily apparent on the AP projection and in the lateral projection utilizing the subtraction technique (Fig. 1), whereby the overlying bony density of the skull is eliminated, so that one can better appreciate these aneurysms as well as irregular narrowing along the course of the posterior-inferior cerebellar artery.

The right carotid angiogram demonstrated the presence of multiple distal aneurysms measuring approximately 5 mm in size and involving the posterior parietal branch and Rolandic-branch of the middle cerebral artery. This is complete occlusion of a small branch of the middle cerebral artery in the region of the supramarginal gyrus. There is no evidence of associated mass lesion or arteriovenous shunting. The anterior cerebral artery and internal cerebral vein are in the mid line. The left carotid angiogram demonstrated the presence of multiple small aneurysms involving distal branches of the middle cerebral artery in the mid and posterior parietal regions and in the posterior temporal lobe area.

It is important to point out in this case that there is no evidence of vascular abnormality involving the main vessels at the base of the brain. The carotid arteries as well as the proximal anterior and middle cerebral arteries are normal in caliber. There are no areas of abnormal staining and the ventricle size as determined by the appearance of the subependymal veins is normal bilaterally. With respect to the extracranial circulation, both carotid bifurcations appeared normal.

An example of the pseudo-aneurysms that were demonstrated with vertebral basilar angiography is shown on the AP view of the vertebral injection. This subtraction film demonstrates excellent filling of the vertebral basilar circulation and reveals the multiple pseudo-aneurysms involving the right anterior-inferior cerebellar artery (small open arrow), left superior cerebellar artery (large open arrow), and distal branches of both the right and left posterior cerebral arteries in the parietal regions (closed arrows).

The angiographic findings described in this



Figure 1. Left vertebral angiogram A-P view. This subtraction radiograph demonstrates the arterial phase of the vertebral injection with excellent filling of the vertebral basilar circulation. Abnormal findings include the presence of a pseudo-aneurysm involving the right anterior-inferior cerebellar artery (small open arrow), another larger fusiform pseudo-aneurysm involving the proximal left superior cerebellar artery (large open arrow), and smaller pseudo-aneurysms involving the distal branches of both the right and left posterior cerebellar arteries in the parietal regions (closed arrows).

patient are those of a cerebral arteritis. The angiographic abnormalities include narrowing and occlusion of vessels with associated stasis of contrast material and multiple aneurysms primarily localized to the distal course of the cerebral arteries. The repeated episodes of what sounds like cerebral emboli in a young patient with no evidence of underlying mitral valvular disease or systemic involvement by connective tissue disorders suggest the possibility of a tumor within the left atrium. This entity was considered in our differential diagnosis of this patient together with an idiopathic cerebral arteritis and periarteritis nodosa. Although clinical findings of atrial myxoma may be inconspicuous or even absent, angiography should be performed since this entity is a treatable cause of the multiple strokes seen in this patient.

**Dr. Ralph Otto:** Because of the history and these findings, cardiology consultation was obtained. A series of special studies finally established the diagnosis.

**Dr. Sheridan Myers:** We obtained a phonocardiogram on the patient with a simultaneous ex-

ternal carotid pulse recording, and demonstrated the first and second heart sounds. The first heart sound was very loud and immediately raised the suspicion of mitral stenosis in a young individual. In addition, following the second heart sound, there was intermittently a very clear third heart sound which showed a very interesting phenomenon. If the respiration stopped, intermittently the diastolic sound would be very soft, sometimes get louder, and at times disappear. It was quite variable in intensity, unlike what would be expected with the opening snap of mitral stenosis. We also recorded the phonocardiogram with an apexcardiogram and the timing of this sound was somewhere between the opening snap of mitral stenosis and a physiological third sound or third sound of ventricular failure, not an uncommon timing for a lesion which prolapses into the left ventricle from the left atrium.

We obtained an echocardiogram on this patient. To briefly familiarize you with the technique, we place an ultrasound transducer on the chest wall. This emits ultrasound waves at a frequency of about 2.25 million cycles per second at an energy level that is not harmful to biologic tissue. The width of the beam is approximately one-half inch and we are able to penetrate right through the mediastinum. We rely upon the difference in acoustic density between one structure and the next to reflect the ultrasound. As we direct the ultrasound beam through the chest, we can record reflected sound from the chest wall, right ventricular wall, the intraventricular septum (actually dening both sides of the septum), left ventricular cavity, posterior papillary muscle and posterior left ventricular wall. We can differentiate the endocardial and epicardial surfaces. We can view the chordae tendineae and the leaflets, the aorta, aortic valve and the left atrium. Normally, the mitral leaflet moves in a very characteristic fashion, the anterior mitral leaflet opening into the left ventricle during diastole, anteriorly towards the front of the chest and the septum. The posterior leaflet moves in the opposite direction symmetrically and has a lesser excursion. During systole, these two leaflets close in apposition.

In the presence of mitral stenosis, the posterior leaflet moves in the same direction as the anterior leaflet rather than posteriorly. In addition, one may see a thickened leaflet. If there is stenosis of the mitral valve and high pressure in the atrium, the anterior mitral leaflet does not close as rapidly as a normal anterior leaflet. When we scanned this patient, as we directed the ultrasound beam from the left ventricle towards the aorta, we re-

corded echoes behind the anterior leaflet of the mitral valve. The anterior mitral leaflet had a characteristic M-shaped motion during diastole and we saw the posterior leaflet move posteriorly and symmetrically opposite to the anterior mitral leaflet. This excluded mitral stenosis.

In addition, we noticed that behind the anterior leaflet of the mitral valve there were some echoes in middle and late diastole. These echoes were not behind the anterior mitral leaflet in late systole. This suggests that something was prolapsing from left atrium into left ventricle during diastole and from left ventricle to left atrium during ventricular systole. The mass also decreased the rate of anterior mitral leaflet closure. During systole, as the ventricle contracted and raised the pressure within the ventricle, this mass was pushed posteriorly into the left atrium.

Thus, we demonstrated a space-occupying lesion, capable of prolapsing between the left atrium and the left ventricle. The left atrium was filled by echoes of reflected ultrasound. We catheterized the patient and found no pressure gradient across the mitral valve, again suggesting the absence of a stenosis. We did a pulmonary angiogram, including angiograms late in the pulmonary venous phase as the left atrium filled and demonstrated a filling defect within the left atrium. The fact that the left auricular appendage was free of any filling defect suggested that this was not clot but was some other atrial mass. We suspected an atrial myxoma. Secondly, the filling defect was seen to prolapse between the left atrium and left ventricle during the cardiac cycle. We felt that we had excluded mitral stenosis. There was no other evidence for a congenital lesion that could have become infected and we did demonstrate a prolapsing, space-occupying lesion of the left atrium.

**Dr. Ralph Otto:** With a diagnosis of left atrial myxoma, the patient was operated upon on January 10th. Through a right thoracotomy and with cardiopulmonary bypass, exploration of his left atrium indeed showed a left atrial myxoma filling the majority of the chamber. It was extracted and found to originate from a small base right around the fossa. This was removed with a portion of the atrial septum, which was then repaired. Care was taken to remove all loose fragments of the tumor and during the operation, the patient's heart was fibrillated to prevent embolization. His postoperative course was unremarkable.

**Dr. Hector Battifora:** The tumor had a distinct gelatinous lobular appearance with wide areas of



**Figure 2.** Gross appearance of atrial myxoma. The tumor had a short fibrous pedicle and numerous focal hemorrhages.

old and recent hemorrhage. It measured about six centimeter at its greatest dimension. It was attached to the atrial wall by a short, narrow fibrous pedicle, (Fig. 2). Histologically, it was made up mostly of amorphous matrix and a few cells here and there, (Fig. 3). The cells, when single, appeared like fibroblasts. More often they grouped in nests and cords reminiscent of budding capillaries, yet lumen could not be seen in most. There is ultrastructural evidence that these are indeed developing vessels. These findings led some to suggest that these are really not myxomas, but angiomyxomas. Basically, the intercellular matrix consists of polysacchariderich ground substance and collagen fibers and their precursors. In addition, there is abundant fibrin, resulting from bleeding into the tumor, possibly as a consequence of the frequent episodes of fragmentation of the tumor by the hemodynamic trauma.

**Dr. Ralph Otto:** Primary cardiac tumors are quite rare, perhaps less than one per thousand autopsies. 80% of primary cardiac tumors are benign, and approximately half are myxomas. Of the malignant tumors, almost all are sarcomas. In contrast, metastatic lesions in the heart are 10-20 times more common. Myxomas, which comprise half of the primary cardiac tumors, are usually found in the atrium although they may be bilateral. There is a slight female predominance. The common signs and symptoms were well illustrated by our patient. In a series of 23 patients from the Mayo Clinic, congestive heart failure predominated, and one-third had embolic episodes. Fatigue, fever, syncope, arrhythmias were less common. The most important physical finding is a changing heart murmur stimulating mitral or tricuspid valve lesions. The initial clinical diagnosis is usually mitral or tricuspid valve disease. Differential diagnosis include endocarditis, constrictive pericarditis, and



**Figure 3.** Microphotograph of myxoma. A few single spindled cells are seen as well as clusters with angioblastic appearance with abundant amorphous matrix.

idiopathic epilepsy. Some patients have been operated on for mitral stenosis and found to have the atrial myxoma at the time of operation. The first atrial myxoma was removed by Craaford in 1954 using cardiopulmonary bypass. At the present time, surgical excision of the lesion including its base which is usually the rim of the fossa valvula with exploration of the other cardiac chamber is the treatment of choice. They may recur if the base of the lesion has not been completely excised.

**Dr. Arthur DeBoer:** I think, just to summarize briefly, there are three things that the case has shown us today. One, of course, is the diagnosis. I remember Dr. Stuteville said one time that what one should do is have the patients talk and they will tell you what the diagnosis is and this is so frequently true. This young man was told originally that he had seizures. Of course, he really didn't have seizures, but he had episodes that were very highly suggestive of emboli. If one thinks in terms of multiple emboli in a youngster, one must find the resource.

Secondly, the diagnostic facilities that we have had demonstrated today is incredible, from my point of view. The cerebral angiograms that you saw show such detail that each vessel can be followed to their capillary bed with clarity. This aids us in making these rare diagnoses. Another phase of diagnostic equipment is the "sonar machine" of Dr. Meyers. It is a non-invasive gadget and is attached similarly onto the chest wall as an electrocardiogram. So easy to do and the abnormalities are so obvious. The sophisticated devices of today help make the diagnosis much easier.

Thirdly, the ease whereby patients can be operated upon today allows much more freedom and safety in removing intra-cardiac tumors. A

(Continued on page 400)

# Doctor's News

**MENTAL HEALTH CODE BEING REVISED**—Mental Health Code Revisions are being developed by the Governor's Commission for Revision of the Mental Health Code. Many of the proposals will bear close scrutiny by physicians. Initial documents which have not been adopted by the Commission would cause creation of a new Illinois Department of Public Advocacy, would identify a rigid Patients Bill of Rights, would lower the age for treatment of minors for mental illness without parental consent, and would create a new category of personnel—a certified mental health examiner. Of serious concern will be to guarantee that a revised Code not be written to control state mental facilities and then be applied to all providers. Various definitions in the proposals, the criteria for care, and any anti-therapeutic orientation also must be reviewed thoroughly by physicians. The Commission is to report a recommended Code in December.

Physicians wishing to obtain copies of any or all documents developed by the Commission should send such request to: The Commission, Room 1620, State of Illinois Building, 160 N. LaSalle St., Chicago, Illinois 60601. Public Hearings will be held at the University of Chicago, Center for Continuing Education, 1307 E. 60th St., on November 14 and 15, 1974.

**SIAM HOSTING 100th MEETING**—The 100th annual meeting of the Southern Illinois Medical Association will be held November 7, 1974, at the Belle-Clair Fairgrounds, Belleville.

The morning program, sponsored jointly by the Illinois Academy of Family Practice and the SIAM, is accepted by the IAFP for two hours prescribed postgraduate study credit and 3 hours of elective post graduate study credit for Academy members.

Subjects and speakers to be presented include: "Practical Management of Diabetes" and "Pituitary Disorders, Diagnosis Management," Richard Byyny, M.D.; and "Cardiovascular Conditions," Arnold Moe, M.D., Robert A. Harp, M.D., and James Dove, M.D.

ISMS President Fredric D. Lake, M.D., will be in attendance as part of his annual President's Tour. ISMS Trustees W. D. Tuttle, M.D., Ninth District, and H. P. Dexheimer, M.D., Tenth District, also will participate at the SIAM meeting.

A banquet will close the one day's activities featuring John W. D. Wright who will speak on the "History of Southern Illinois." A social hour will precede the dinner which is being hosted by the Illinois State Medical Society and the Illinois State Trust Company, East St. Louis.

**PHYSICIANS IN THE NEWS**—Fernando Francisco-Lopez, M.D., Medical Director and Chairman, Continuing Medical Education at Martha Washington Hospital, Chicago, has been nominated "Outstanding New Citizen" 1973-74 by the Citizenship Council of Chicago and the Immigration Service Department of Justice.

New officers of the Chicago Gynecological Society are: John P. Harrod, M.D., President; Lester D. Odell, M.D., President Elect; Augusta Webster, M.D., Vice-President; Robert E. Lane, M.D., Secretary; John C. Buckingham, M.D., Assistant Secretary; and Mario Oriatti, M.D., Treasurer.

Raymond McDonald, M.D., has been appointed as Medical Director of Emergency Room Services at Westlake Hospital, Melrose Park. Alfred Faber, M.D., Glenview, recently was appointed to the Council on Legislation of the American Medical Association.

Effective September 1, Harry Auerback became Executive Director of the Illinois Regional Medical Program. Auerback succeeds **Morton C. Creditor, M.D.**, now Associate Dean of the University of Illinois School of Basic Medical Sciences, Urbana.

New appointments at Evanston Hospital, Evanston, include: **Edward F. Scanlon, M.D.**, Chairman of the Department of Surgery; **Donald C. Greaves, M.D.**, Chairman of Department of Psychiatry; and **Thomas Killip III, M.D.**, Chairman of Department of Medicine.

### ISMS President In Hong Kong

This past summer ISMS President **Fredric D. Lake, M.D.** and Mrs. Lake were among the many Illinois physicians and spouses who went on the ISMS sponsored Orient Adventure. Travel arrangements were handled by INTRAV of St. Louis.

While in Hong Kong the group stayed at the Mandarin. Dr. Lake (center) is pictured at right with the General and Assistant Managers of the Mandarin.



### *Physicians and Legislators Confer at a Unique Legislative Seminar*



Among the participants at the Legislative Seminar were, (from left to right): Senator Howard Mohr, Forest Park; Senator William Harris, Pontiac; Don Hinderliter, M.D., and Senator John Roe, Rochelle.



Time out for a break! Gathered during the weekend conference were, (from left to right): Robert Fox, M.D., Representative Harold Katz, Glencoe; and Representative and Mrs. Pete Peters, Chicago.

Over 210 physicians, legislators and spouses attended the unique Legislative Seminar September 20-22, 1974, at the Chateau Louis in Dundee. This seminar was hosted by the ISMS Public Affairs Committee chaired by **Elliot Partridge, M.D.**, and Smith Kline & French pharmaceutical company. SK & F has been conducting nationwide legislative seminars with the ISMS Conference being the 30th.

The purpose of the weekend conference was to offer the physicians and legislators a chance to discuss mutual problems. During the informal discussions, legislators indicated that personal letters from physicians on health care matters weighed heavily with them. Also, it was stressed that physicians were needed to testify on health care legislation during hearings and to be available for consultation.



## ***President's Page***

# Faulty Communication

Monumental forces are at work to reshape the practice of medicine, suppress our professional freedom by legislative edict and curb our professional judgment by bureaucratic fiat.

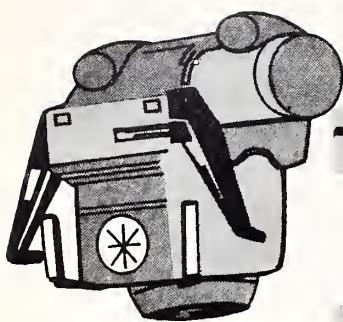
Our ability to defend our profession is weakened by the divisiveness in our ranks and by the vast apathy of our membership coupled with considerable ignorance of the issues.

While faulty communication is largely to blame for this ignorance, I would note that ISMS has made vigorous efforts to disseminate this information. However, the signals don't get there.

We need some means of attracting the membership to "tune in."

If we could only channel the exchange of the hospital "doctors' lounge" into the meeting rooms of the medical society, we might be able to achieve effective communication.

A handwritten signature in cursive script that reads "Fredric D. Labbe".



## the viewbox

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLoGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

# Computerized Axial Tomography With The EMI-Scanner at Loyola University Medical Center

BY ENRIQUE PALACIOS, M.D., BEHROOZ AZAR KIA, M.D., AND  
LEON LOVE, M.D./MAYWOOD

It is now possible to obtain a three-dimensional look deep into the human head, thanks to the computerized brain scanner just installed at the Radiology Department of the Loyola University Medical Center in Maywood.

The photographs shown are sections of the head obtained by the new system, transverse axial tomography, which has been developed to obtain greater information from the X-rays through the head, and to present the information obtained in the most useful form for evaluation by the neuroradiologists.

Computerized axial tomography has demonstrated the facility for discriminating between tissues of minutely varying densities, providing more accurate diagnostic information in different brain lesions. This method also has been found useful in orbital lesions.

The diagnostic study with this new noninvasive technic can be carried out on an out patient basis in a short period of time, and eliminates discomfort and morbidity which may be associated with the other conventional roentgenographic procedures such as pneumography and angiography.

The authors are from the Loyolo University Medical Center and Loyolo University Stritch School of Medicine in Moywood. ENRIQUE PALACIOS, M.D. is Associate Professor of Rodiology, Neuroradiology Section; BEHROOZ AZAR KIA, M.D. is Assistant Professor of Rodiology, Neuroradiology Section; and LEON LOVE, M.D. is Professor and Chairman, Department of Rodiology.

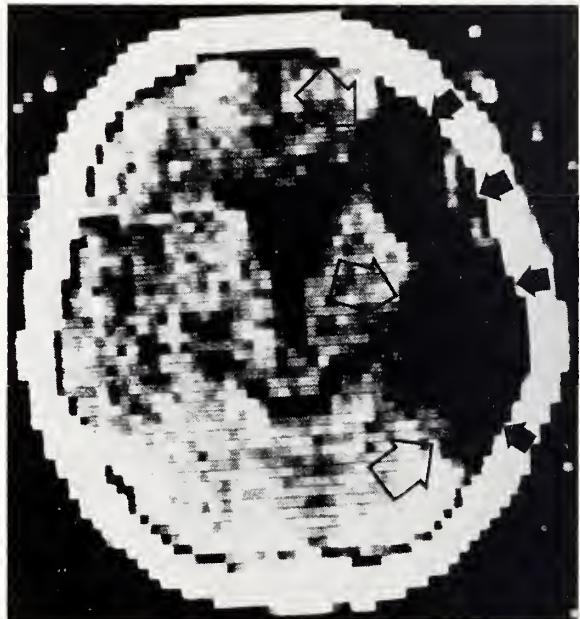


Fig. 1 Massive infarction, right cerebral hemisphere (arrows) secondary to middle cerebral thrombosis in a 65-year-old male.



Figure 2

**Fig. 2. Basal Ganglia Hemorrhage in a 26-year-old female (arrows).**

**Fig. 3. Symmetrical Ventricular enlargement and dilation of the Sulci, due to superficial and deep cerebral atrophy in a 47-year-old male with presenile dementia.**

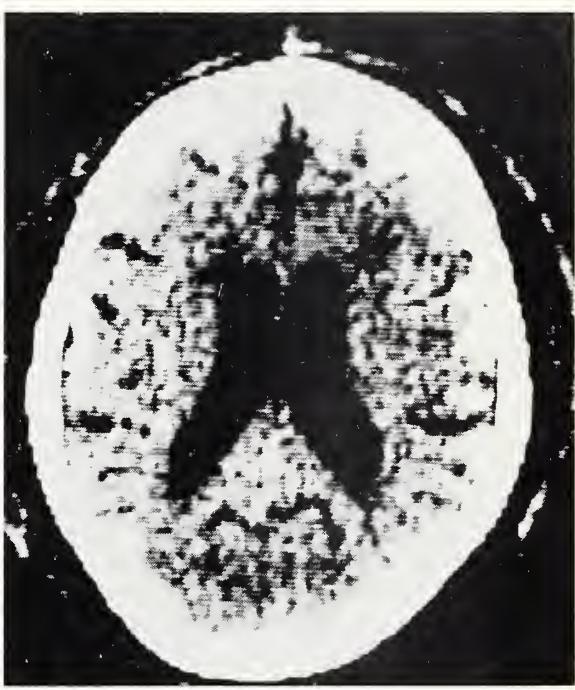


Figure 3

**Fig. 4. (A) Section at the level of the anterior horns of the Lateral Ventricle, demonstrating marked displacement to the left. (Arrows)**

**(B) A higher section reveals a large dense tumor mass. A Glioblastoma in the right occipito parietal region in a 48-year-old male.**

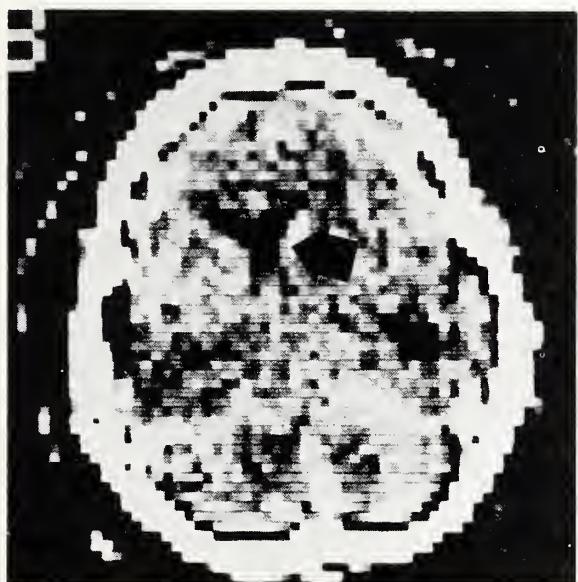


Figure 4A

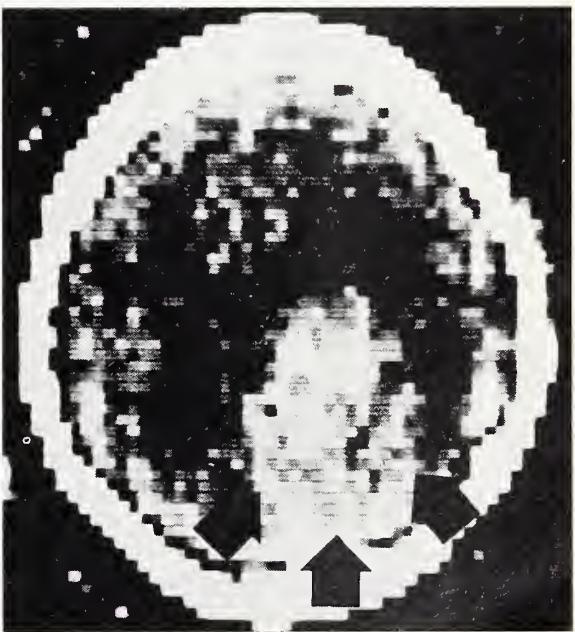
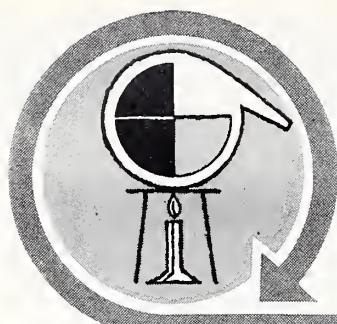


Figure 4B



# new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**Single Chemicals**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

## The following new drugs have been marketed:

### SINGLE CHEMICALS

|                      |  |    |
|----------------------|--|----|
| <b>NIPRIDE</b>       | Hypotensive  | Rx |
| Manufacturer:        | Roche Laboratories   |    |
| Nonproprietary Name: | Sodium Nitroprusside   |    |
| Indications:         | Hypertensive crises  |    |
| Contraindications:   | Compensatory hypertension, e.g., arteriovenous shunt or coarctation of the aorta.    |    |
| Warnings:            | Use only as an infusion with sterile 5% dextrose in water. Not for direct injection. |    |
| Dosage:              | Follow instructions in package insert.   |    |
| Supplied:            | Vials, 5cc/50 mg.<br>For reconstitution with dextrose in water.                      |    |

### DUPLICATE SINGLE DRUGS

|                      |   |    |
|----------------------|---|----|
| <b>NEFRUSOL</b>      | Sulfonamide   | Rx |
| Manufacturer:        | Riker Laboratories, Inc.  |    |
| Nonproprietary Name: | Sulfachloropyridazine   |    |
| Indications:         | Urinary tract infections  |    |
| Contraindications:   | Those usual for sulfonamides  |    |
| Dosage:              | Adults: initial—2 to 4 Gm.<br>maintenance—2 to 4 Gm./24 hrs. divided doses<br>Children over 2 months of age:<br>initial 1 to 2 Gm.<br>maintenance—150 mg./kg./24 hrs.<br>Tablets, 500 mg. |    |
| Supplied:            |   |    |

|                      |   |    |
|----------------------|---|----|
| <b>SOXO</b>          | Sulfonamide   | Rx |
| Manufacturer:        | Sutcliff & Case   |    |
| Nonproprietary Name: | Sulfisoxazole   |    |
| Indications:         | Urinary tract infections  |    |
| Contraindications:   | Those usual for sulfonamides  |    |
| Dosage:              | Adults: initial—2 to 4 Gm.<br>maintenance—2 to 4 Gm./24 hrs. divided doses<br>Children over 2 months of age:<br>initial—1 to 2 Gm.<br>maintenance—150 mg./kg./24 hrs.<br>Tablets, 500 mg. |    |
| Supplied:            |   |    |

### COMBINATION PRODUCTS

|                    |  |    |
|--------------------|--|----|
| <b>DESQUAM-X5</b>  | Dermatological Preparation   | Rx |
| Manufacturer:      | Westwood Pharmaceuticals, Inc.   |    |
| Composition:       | Benzoyl peroxide 5%<br>Polyoxyethelene lauryl ether 6%<br>Ethyl alcohol 37%  |    |
| Indications:       | Carboxy vinyl copolymer  |    |
| Contraindications: | Disodium edetate   |    |
| Dosage:            | Di-isopropanolamine  |    |
| Supplied:          | Acne vulgaris<br>Susceptibility to ingredients<br>After washing rub into affected areas twice daily.<br>Plastic tube, 42.5 Gm. |    |

### NEW DOSAGE FORMS

|                          |   |    |
|--------------------------|---|----|
| <b>PRONESTYL TABLETS</b> | Antiarhythmic   | Rx |
| Manufacturer:            | E. R. Squibb & Sons   |    |
| Nonproprietary Name:     | Procaineamide HCl   |    |
| Indications:             | Premature ventricular contractions and ventricular tachycardia, atrial fibrillation, and paroxysmal atrial tachycardia. |    |
| Contraindications:       | Hypersensitivity to the drug, myasthenia gravis, complete atrioventricular heart block and similar conditions.          |    |
| Dosage:                  | Follow instructions in package insert.  |    |
| Supplied:                | Coated tablets: 250, 375, and 500 mg.   |    |



## Housestaff Contracts

The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

Of the many important housestaff issues raised at the AMA convention this past June, the proposed guidelines for housestaff contracts remains the most hotly debated of all. Last year, the House of Delegates of the AMA directed that a model housestaff contract be developed and submitted to the AMA for approval. After thorough investigation, it became clear to those working on the project that it would be impossible to develop a single contract that would be applicable to all training programs. Thus, the guidelines were developed with the help of housestaff members, members of the Board of Trustees of the AMA, and the Office of the General Counsel of the AMA. It was hoped that these guidelines could be distributed to all of the training centers and molded to suit each individual institution. It was with this in mind that the guidelines (Board of Trustees Reports P and Z) were presented to the House of Delegates in June of this year.

The guidelines came under attack from a number of interested groups, criticism being directed primarily at its alleged "unionistic" approach, its "one-sidedness," and its method of dealing with grievance procedures. In an effort to answer and actively respond to these criticisms, the guidelines were again revised and re-submitted. In spite of the new revision, the House of Delegates elected to postpone final approval of the guidelines until more study was done. Currently, the revised guidelines have been referred back to committee with the understanding that they will be examined by all interested groups (including the AAMC and the AHA) and the final report acted upon at the December AMA meeting in Portland. Hopefully, the guidelines will then be distributed to the training programs across the country for use in negotiations for housestaff contracts.

The document itself is lengthy, but some of the more significant items from it include:

*Position, salary and all other benefits should remain in effect without regard to rotational assign-*

*ments, even if they are away from the parent institution.*

*Adequate, prior notification of the institution's intention not to renew an individual's contract should be required so that the Housestaff Officer will have sufficient time to obtain another appointment.*

*There should be a recognition of the fact that long duty hours extending over an unreasonably long period of time or onerous oncall scheduling are not consistent with the primary objective of education or the efficient delivery of optimum patient care. The institution should commit itself to fair scheduling of duty time for all Housestaff members as well as the provision of adequate and defined off-duty hours.*

*The contract should specify the amount of Professional Liability Insurance which the institution will provide for each Housestaff member, together with the limits of liability applicable to such coverage.*

*The agreement should provide for adequate, comfortable, safe and sanitary facilities such as on-call rooms, secure storage areas, security personnel, facilities for books, storage of clothing, comfortable sleeping quarters, and limitation of the number of beds per room.*

*There should be proscription against regular and recurrent performance of duties by Housestaff Officers unrelated to Housestaff Officer training.*

*The contract could provide that a Housestaff Officer is free to use his off-duty hours as he sees fit, including engaging in outside employment so long as such activity does not interfere with obligations of the Housestaff member to the institution or to the effectiveness of the educational program he is pursuing.*

While the above listing is far from complete, it represents the type of information available in the guidelines. It is hoped that upon final approval, these guidelines will be available to all housestaff members. ▀

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- ▲ Milwaukee Psychiatric Hospital      { Intensive, dynamic psychotherapy for adults and adolescents, individually planned activity therapy.
- ▲ Milwaukee Sanitarium      { Geriatric program of superior care . . . custodial services for persons with chronic emotional illness.
- ▲ Dewey Center      { Acute detoxification and inpatient treatment for alcoholic dependency, daily schedules, broad supportive services.

Units of: MILWAUKEE SANITARIUM FOUNDATION

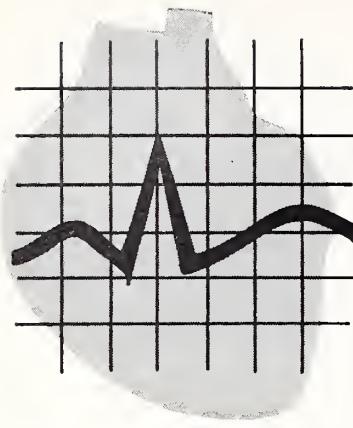
1220 DEWEY AVENUE • WAUWATOSA, WIS. 53213 • PHONE (414) 258-2600

Affiliated with Medical College of Wisconsin

Accredited by the Joint Commission on Accreditation of Hospitals

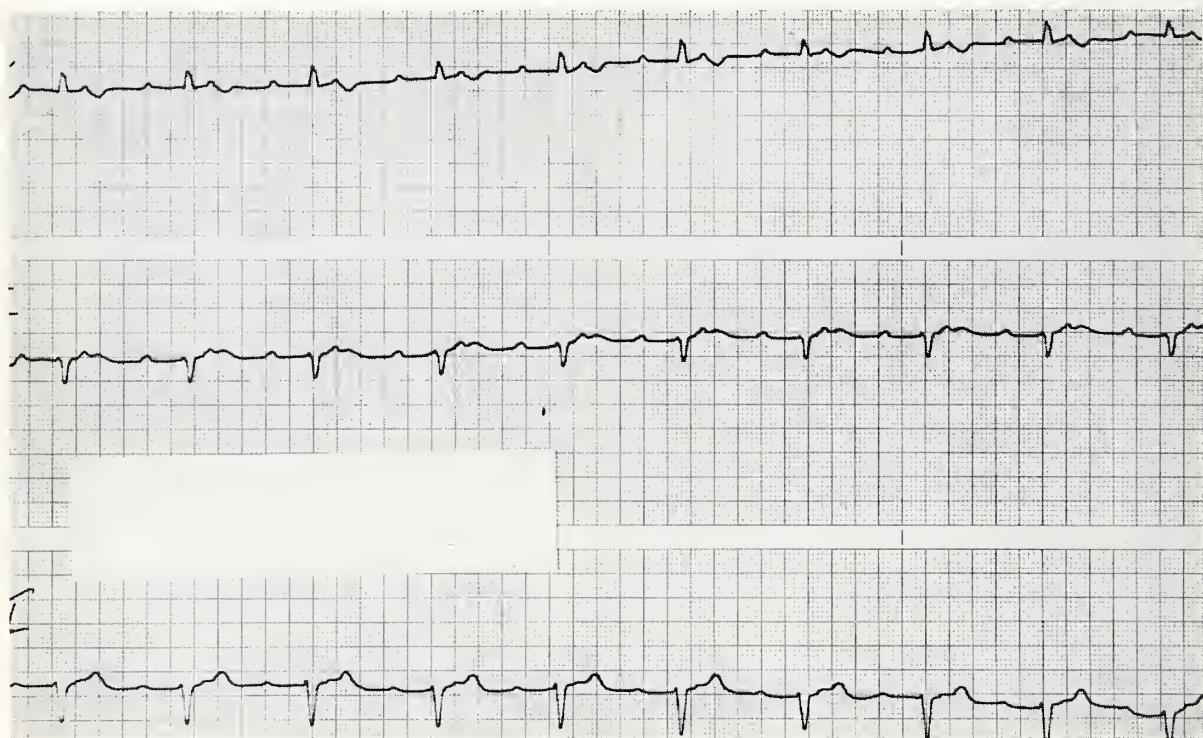
Non-Profit Non-Sectarian Est. 1884 Participating Member Blue Cross-Blue Shield





## ekg of the month

JOHN R. TOBIN, M.D., M.S., RIMGAUDAS, NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
JAMES V. TALANO, M.D., SARAH JOHNSON, M.D. and  
ROLF M. GUNNAR, M.D., M.S./Section of Cardiology,  
Loyola University Stritch School of Medicine



A 61-year-old housewife was seen in the emergency room following a syncopal episode. For the preceding few weeks she had experienced palpitations and occasional feeling of lightheadedness unrelated to activity. She took no drugs. On examination there was a hematoma on the forehead. Pulse was 60 and regular. S<sub>1</sub> was soft and S<sub>4</sub> was heard at the apex. Simultaneous 3 lead rhythm strip was taken (Leads I, II and III).

Questions:

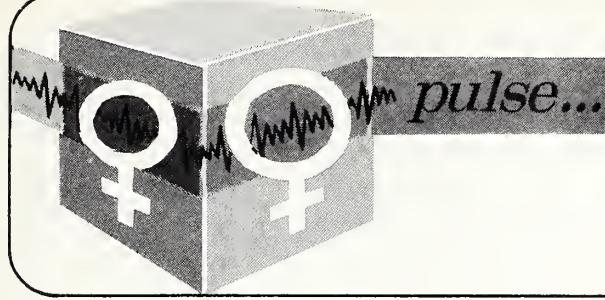
**1. The rhythm strip shows:**

- A. Sinus bradycardia.
- B. Second degree AV block Mobitz Type I.
- C. Second degree AV block Mobitz Type II.
- D. Complete AV block.
- E. Two to one AV block.

**2. The treatment should include:**

- A. Electrocardiographic monitoring.
- B. Insertion of temporary pacemaker.
- C. Bundle of His recordings.
- D. Exclusion of other causes of syncope.
- E. All of the above.

(Answers on page 403)



## of the doctor's wife

MRS. HAROLD KEEGAN, Editor

### What's in the Future

In the last week I have received much information from our state chairmen. I bring to your attention the following communications.

Jane Klaren, Vice-President (Programs), has set-up a "Speakers Bureau" suggesting to stress topics such as communications and leadership. Jane states that it is important to "wrap the package" attractively and to look for different and thought provoking programs. The list of speakers and programs are available thru your local chairman or president.

Betty Szewczyk, Vice-President (Community Health), states that we should be leaders in community health. We can accomplish this by: 1. survey your community and schools for health needs; 2. offer to assist during IAM (Immunization Action Month); 3. join the physical fitness action club; and 4. communicate with other groups in your area.

Flo Cunningham, Religion and Medicine Chairman, is initiating the presentation of a "Humanitarian Award" to be presented at the next annual state convention in Chicago. The object is to recognize an Illinois State woman who has accomplished special achievements in a health field.

\* \* \*

### Happiness Is . . . .

Mrs. Richard Graff of Kankakee County, has added some words to the song "Happiness is ---" written by Paul Parnes and Paul Evans. "Happiness is ---" Mrs. Glatter's theme for this year.

for October, 1974

Happiness is ----  
Happiness is ----  
Happiness is ----  
Different things to different people  
That's what happiness is!  
On a desert it's a drink, drink, drink!  
To a show girl it's a mink, mink, mink!  
To a banker—lots and lots of dough  
To a racer—it's a G.T.O.!  
That's what happiness is!  
To Auxiliary it's a cause, cause, cause  
For each County it's applause, applause!  
For the State it means "No shirt—No Quirk!"  
And for National it's a good year's work!  
That's what happiness is!

\* \* \*

#### NOTE:

Due to the lack of material, the September quarterly "PULSE" will be issued in October.

\* \* \*

#### REMINDER:

October is "IMMUNIZATION ACTION MONTH".

\* \* \*

#### DON'T FORGET—These District Meetings:

November 7—District 9 & 10—Exposition Hall, Belleville, Ill.

February 11—District 3—Regency Hyatt House, Chicago, Ill.

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
360 No. Michigan Ave. • Chicago, IL 60601 • (312) 782-1654



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events.

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## NOVEMBER

### Alcoholism

#### FIRST ANNUAL SYMPOSIUM ON ALCOHOLISM

For: All physicians. Nov. 13, 1974, 9:00-11:00 AM, Robt. C. Hartmann, Sr., Auditorium, Martha Washington Hosp., Chicago. **CME Credit:** 2 hrs. AMA Category 1, AAFP Elective. Reg. Limit: 110. Sponsor, contact: F. Lopez-Fernandez, M.D., Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chicago, 60618.

### Basic Science

#### SEX PROBLEMS IN MEDICAL PRACTICE

For: All Physicians, Allied Health. Weekly seminar, Nov. 5, 1974, 11:30 AM, Memorial Hosp. of DuPage Co., Elmhurst, Ill. Speaker: D. Renshaw, M.D., Loyola Univ. **CME Credit:** 1 hr. AMA Category 1. Sponsor, contact: J. H. Huss, M.D., Dir. Med. Educ., Memorial Hosp. of DuPage Co., Avon Rd. & Schiller St., Elmhurst 60126.

#### THE THORACIC OUTLET SYNDROME

For: All Physicians, Allied Health. Weekly seminar, Nov. 26, 1974, 11:30 AM, Memorial Hosp. of DuPage Co., Elmhurst, Ill. Speaker: J. Conn, Jr., M.D., **CME Credit:** 1 hr. AMA Category 1. Sponsor, contact: J. H. Huss, M.D., Dir. Med. Educ., Memorial Hosp. of DuPage Co., Avon & Schiller St., Elmhurst, 60126.

### Cardiovascular

#### MANAGEMENT OF ACUTE MYOCARDIAL INFARCTION

For: All Physicians. Symposium, Nov. 12, 1974, 8:30 AM, Westlake Community Hosp., Melrose Park, Ill. Speaker: J. Messer, M.D., Presbyterian-St. Luke's Hosp. **CME Credit:** 1½ hrs. AMA Category 2. Sponsor, contact: Westlake Community Hosp., 1225 Superior St., Melrose Park, IL 60160; (312) 681-3000.

### Cancer

#### TUMOR BOARD

For: All Physicians. Bi-monthly meeting, Nov. 5 & 19, 1974, 8:30 AM, Westlake Community Hosp., Melrose Park, Ill. **CME Credit:** 1 hr. each, AMA Category 2. Sponsor, contact: Westlake Community Hosp., 1225 Superior St., Melrose Park, IL 60160.

### Dermatology

#### CUTANEOUS MEDICINE

For: All physicians. Frontiers of Medicine lecture, Nov. 13, 1974, Billings Hospital, Chicago. **CME Credit:** 3 hrs. AMA Category 1, AAFP. Fee: \$20. Sponsor, contact: Frontiers of Medicine, Univ. of Chicago, Box 451, 950 E. 59th St., Chicago 60637.

### Family Medicine

#### FAMILY PRACTICE REVIEW

For: Family Physicians. Nov. 4-8, 1974, Chicago. **CME Credit:** 40 hrs. (approx.) AMA Category 1. Fee: \$175. Reg. Limit: 50. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

#### TREATMENT OF COMMON DERMATOLOGICAL PROBLEMS SEEN BY EVERY PHYSICIAN

For: All physicians. Lecture, Nov. 19, 1974, 7:30 PM, Sherman Hosp., Elgin, Ill. Speaker: J. Cox, M.D., Univ. of Ill. **CME Credit:** 2 hrs. AMA Category 1. Sponsor, contact: W. E. Gasser, M.D., CME Comm., Sherman Hosp., 934 Center St., Elgin, IL 60120.

### General Medicine

#### WEBER MEDICAL CLINIC FALL SEMINAR

For: Generalists. Seminar, Nov. 2, 1974, Olney Central College, Olney, Ill. **CME Credit:** 4 hrs. AMA Category 2. Reg. Deadline: Oct. 25, 1974. Sponsor, contact: D. L. Potter, Admin., Weber Medical Clinic, 1200 N. East St., Olney, 62450. Co-Sponsor: SIU Sch. of Med.

#### GENERAL MEDICINE LECTURE SERIES—PART I

For: All physicians & house staff. Weekly lecture series, Nov. 5, 12, 19, & 24, 1974, St. Mary of Nazareth Hosp. Ctr., Chicago. **CME Credit:** 1½ hrs. each, AAFP Elective. Sponsor, contact: St. Mary of Nazareth Hosp. Ctr., Dept. of Med. Educ., 1120 N. Leavitt St., Chicago, IL 60622.

#### ANNUAL POST-GRADUATE ASSEMBLY OF S.I.M.A.

For: All physicians. Annual post graduate seminar, Nov. 7, 1974, Belle-Clair Fairgrounds, Convention Ctr., Belleville, Ill. Topics: Cardiology, Diabetes & Endocrinology. **CME Credit:** 4 hrs. AMA Category 2, 2 hrs. AAFP. Sponsor, contact: W. H. Walton, M.D., Southern Ill. Med. Assn., 109 S. High St., Belleville, IL 62220.

#### CARLE CLINICAL CONFERENCE & LECTURE

For: All Physicians, Dentists. Clinical conference, Nov. 13, 1974, Ramada Convention Ctr., Champaign, Ill. **CME Credit:** 4 hrs. AAFP. Sponsor, contact: Carle Foundation, 611 W. Park St., Urbana, IL 61801.

#### SEMINAR ON SURGERY & MEDICINE FOR LAKE COUNTY

For: Physicians, Dentists & Nurses. Seminar, Nov. 20, 1974, St. Therese Hosp., Waukegan, Ill. **CME Credit:** 5 hrs. AAFP, AMA Category 2. Reg. Limit: Deadline: 250; Nov. 8, 1974. Sponsor, contact: R. M. Adelman, D.O.S., M.D., St. Therese Hosp., 2615 W. Washington, Waukegan, IL 60085.

### Infectious Disease

#### ADVANCES IN INFECTIOUS DISEASES

For: All Physicians, Nurses. Lecture, Nov. 7, 1974, 11:00 AM, Martha Washington Hosp., Chicago. Speaker: M. Mufson, M.D., Univ. of Ill. **CME Credit:** 1 hr. AMA Category 1, AAFP Prescribed. Sponsor, contact: F. Lopez-Fernandez, M.D., Med. Dir., Martha Washington Hosp., 4055 N. Western, Chicago, 60618.

### Internal Medicine

#### BASIC INTERNAL MEDICINE

For: All physicians. Nov. 11-15, 1974, Chicago. **CME Credit:** 40 hrs. (approx.) AMA Category 1. Fee: \$175. Reg. Limit: 50. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

#### VENEREAL DISEASES

For: All Physicians. Short course, Nov. 13, 1974, Gary, Ind. **CME Credit:** 6 hrs. AMA Category 1, AAFP. Fee: \$35. Sponsor, contact: Postgrad. Med. Educ., Indiana Univ. Sch. of Med., 1100 W. Michigan, Indianapolis, IN 46202. Co-Sponsor: Indiana Acad. Family Phys.

#### DISEASES OF LIVER & G.I. TRACT

For: All Physicians. Group discussion & lecture, Nov. 15, 1974, 10:00 AM, Belmont Community Hosp.; Nov. 15, 6:00 PM, Lincolnwood Hyatt House; Nov. 16, 10:00 AM, American Hosp. of Chgo., Chicago. Speakers: S. E. Goldfinger, M.D., Harvard Med. Sch. **CME Credit:** 5 hrs. AMA Category 1, AAFP. Fee: \$10 (non-staff, for dinner). Reg. Deadline: Nov. 11, 1974. Sponsor: FAB/CME. Contact: Mr. J. McCracken, Belmont Community Hosp., 4058 W. Melrose St., Chicago, IL 60641; (312) 736-7000.

### Laryngology

#### ELECTROLYTE IMBALANCE IN CLINICAL PRACTICE

For: All Physicians, Nurses. Lecture, Nov. 21, 1974, 11:00 AM, Martha Washington Hosp., Chicago. Speaker: N. Kurtzman, M.D., Univ. of Illinois. **CME Credit:** 1 hr. AMA Category 1, AAFP Prescribed. Sponsor, contact: F. Lopez-Fernandez, M.D., Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chicago, IL 60618; (312) 583-9000, ext. 331.

### Neurology

#### LARYNGOLOGY & BRONCHOESOPHAGOLOGY

For: All physicians. Symposium, Nov. 18-23, 1974, Chicago. Hrs. of Instr.: 42. Fee: \$300. Reg. Limit: Deadline: 20; Nov. 17, 1974. Sponsor, contact: Univ. of Ill. Abraham Lincoln Sch. of Med., 1855 W. Taylor St., Chicago, IL 60612.

### Obstetrics-Gynecology

#### NEUROPHYSIOLOGICAL & CLINICAL ASPECTS OF ACUPUNCTURE

For: Physicians, Surgeons, Dentists. 3-day conference, Nov. 7-9, 1974, Hilton Hotel, Madison, Wis. **CME Credit:** AAFP Prescribed, AMA Category 1. Fee: \$90 (before Sept. 1); \$110 (after Sept. 1). Sponsor, contact: Dept. of Cont. Med. Educ., Univ. of Wis., 610 N. Walnut St., Madison, WI 53706.

### Orthopaedics

#### FEMALE CLIMACTERIC

For: All physicians, allied health. Weekly seminar, Nov. 19, 1974, Memorial Hospital of DuPage Co., Elmhurst, Ill. Speaker: A. Scrommegna, M.D., Michael Reese Hosp. **CME Credit:** 1 hr. AMA Category 1. Sponsor, contact: J. H. Huss, M.D., Dir. Med. Educ., Mem. Hosp. of DuPage Co., Avon Rd. & Schiller St., Elmhurst, IL 60126; (312) 833-1400, ext. 556.

#### PRACTICAL OBSTETRICS & GYNECOLOGY

For: Specialists & Family Physicians. Short course, Nov. 20, 1974, Airport Holiday Inn, Indianapolis. **CME Credit:** 6 hrs. AMA Category 1, AAFP. Fee: \$35. Sponsor, contact: Postgrad. Med. Educ., Indiana Univ. Sch. of Med., 1100 W. Michigan, Indianapolis, IN 46202. Co-Sponsor: Indiana Acad. Family Phys.

### Psychiatry

#### OFFICE ORTHOPAEDICS

For: All Physicians. Short course, Nov. 6, 1974, Indianapolis. **CME Credit:** 6 hrs. AMA Category 1, AAFP. Fee: \$35. Sponsor, contact: Postgrad. Med. Educ., Indiana Univ. Sch. of Med., 1100 W. Michigan, Indianapolis, IN 46202.

### Respiratory Disease

#### ON DEATH & THE CONTINUITY OF LIFE

For: All physicians. Lecture, discussion, Nov. 20, 1974, 7:30 PM, Forest Hosp. Professional Ctr., Des Plaines, Ill. Speaker: R. Lifton, M.D., Yale Univ. Fee: \$15 (\$5 students). Sponsor, contact: Forest Hosp., 555 Wilson Lane, Des Plaines, IL 60016.

### Illinois Medical Journal

#### RESPIRATORY CARE CONFERENCE

For: All Physicians. Monthly meeting, Nov. 26, 1974, 8:30 AM, Westlake Community Hosp., Melrose Park, Ill. **CME Credit:** 1 hr. AMA Category 2. Sponsor, contact: Westlake Community Hosp., 1225 Superior St., Melrose Park, IL 60160; (312) 681-3000.

## Radiology

### EIGHTH ANNUAL CONFERENCE ON RADIOLOGY IN OTOLARYNGOLOGY & OPHTHALMOLOGY

For: Radiologists, Otolaryngologists, Ophthalmologists. Conference, Nov. 29-30, 1974, 8:30 AM-5:00 PM, Eye & Ear Infirmary, Univ. of Ill., Chicago. Speaker: G. E. Valvassori, M.D. CME Credit: 16 hrs. AMA Category 2. Fee: \$90. Reg. Limit: 100. Sponsor: Univ. of Ill. Coll. of Med., Dept. of Radiology. Contact: Ms. J. Whitener, Univ. of Ill. Coll. of Med., Cont. Educ. Services, 1853 W. Polk St., Chicago, IL 60612; (312) 996-3500.

## Surgery

### SPECIALTY REVIEW, PART I

For: Specialists, Nov. 4-15, 1974, Chicago. CME Credit: 94 hrs. (approx.) AMA Category 1. Fee: \$350. Reg. Limit: 150. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

### BLOOD VESSEL SURGERY

For: Specialists, Nov. 18-22, 1974, Chicago. CME Credit: 40 hrs. (approx.) AMA Category 1. Fee: \$300. Reg. Limit: 40. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

## MEDICINE FOR TODAY—Fall Sessions

**For:** All practicing physicians, house staff. IAFP's 26th Annual Lecture Series, with A-V and Q&A supplement. Emphasis on Orthopedics, Psychiatry, Endocrinology, & Pulmonary Function. CME Credit: 30 hrs. (maximum, for Fall & Spring sessions) AAFP Prescribed, AMA Category 1. Fee: \$90 AAFP mbrs., \$100 non-mbrs. Meets in these cities on dates noted:

**Belleville**—Oct. 31, Nov. 7, 14, 21, Dec. 5, 12.

**Berwyn**—Oct. 30, Nov. 6, 13, 20, Dec. 4, 11.

**Centralia**—Nov. 6, 20, Dec. 4.

**Champaign**—Oct. 31, Nov. 14, Dec. 5.

**Chicago Nearwest**—Oct. 30, Nov. 6, 13, 20, 27, Dec. 4.

**Chicago North**—Nov. 6, 13, 20, 27, Dec. 4, 11.

**Chicago Southwest**—Oct. 30, Nov. 6, 13, 20, 27, Dec. 4.

**Harvey**—Oct. 30, Nov. 6, 13, 20, 27, Dec. 4.

**Hinsdale**—Oct. 30, Nov. 13, 27.

**Melrose Park**—Oct. 30, Nov. 6, 13, 20, 27, Dec. 4.

**Park Ridge**—Oct. 30, Nov. 6, 13, 20, 27, Dec. 4.

**Peoria**—Oct. 31, Nov. 14, Dec. 5.

**Rockford**—Oct. 31, Nov. 7, 14, 21, Dec. 5, 12.

**Rock Island**—Nov. 7, 14, Dec. 5.

**Springfield**—Oct. 31, Nov. 21.

For details of time and place, contact: Ill. Academy Family Phys., 14 E. Jackson Blvd., Suite 1532, Chicago, IL 60604.

## DECEMBER

## Pediatrics

### CURRENT PEDIATRIC MANAGEMENT

For: All Physicians. Short course/workshop, Dec. 4, 1974, Indianapolis. CME Credit: 6 hrs. AMA Category 1. AAFP. Fee: \$35. Sponsor, contact: Postgrad. Med. Educ., Indiana Univ. Sch. of Med., 1100 W. Michigan, Indianapolis, IN 46202.

## Respiratory Disease

### FUNGAL DISEASES OF THE LUNG

For: All Physicians, Nurses, Lecture, Dec. 18, 1974, 11:00 AM, Martha Washington Hosp., Chicago. Speaker: R. Briney, M.D., Suburban Hosp. & Sanitorium. CME Credit: 1 hr. AMA Category 1, AAFP Prescribed. Sponsor, contact: F. Lopez-Fernandez, M.D., Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chicago 60618. Co-sponsor: Chicago Lung Assn.

## Surgery

### SURGERY OF TRAUMA

For: All Physicians: 4-day course, Dec. 9-12, 1974, Chicago. CME Credit: 28 hrs. AMA Category 1. Fee: \$175. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

### SPECIALTY REVIEW SURGERY, PART II

For: Surgeons. 2-week course, Dec. 2-13, 1974, Chicago. CME Credit: 99 hr. AMA Category 1. Fee: \$350. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

### SPECIALTY REVIEW—THORACIC SURGERY

For: Surgeons. 1-week course, Dec. 9-13, 1974, Chicago. CME Credit: 40 hrs. AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

## Trauma

### URINARY TRACT INJURY ASSOCIATED WITH PELVIC TRAUMA

For: All Physicians. Allied Health. Weekly seminar, Dec. 3, 1974, Memorial Hosp. of DuPage Co., Elmhurst, Ill. Speaker: S. Clark, M.D., Univ. of Illinois. CME Credit: 1 hr. AMA Category 1. Sponsor, contact: J. H. Huss, M.D., Dir. Med. Educ., Memorial Hosp. of DuPage Co., Avon Rd. & Schiller St., Elmhurst, Ill. 60126.

## Family Medicine

### PSYCHIATRY FOR THE NON-PSYCHIATRIST

For: All physicians. Lecture, Dec. 11, 1974, 12:30 PM, Community Hospital, Geneva, Ill. Speaker: H. Strassman, M.D., Chicago Med. Sch. CME Credit: 3 hrs. AMA Category 1, AAFP Elective. Sponsor, contact: Community Hosp., 416 S. Second St., Geneva, IL 60134.

### SYMPOSIUM ON SHOCK

For: All Physicians. 2-day symposium, Dec. 13-14, 1974, Chicago. CME Credit: 10 hrs. AMA Category 1. Fee: \$75. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

## General Medicine

### GENERAL MEDICINE LECTURE SERIES—PART I

For: All physicians & house staff. Weekly lecture series, Dec. 3, 10, & 17, 1974, St. Mary of Nazareth Hosp. Ctr., Chicago. CME Credit: 1½ hrs. each, AAFP Elective. Sponsor, contact: St. Mary of Nazareth Hosp. Ctr., Dept. of Med. Educ., 1120 N. Leavitt St., Chicago, IL 60622.

## Internal Medicine

### INTRARENAL DISTRIBUTION OF ANTIBIOTICS IN HEALTH & DISEASE

For: All Physicians. Lecture, Dec. 5, 1974, 11:00 AM, Martha Washington Hosp., Chicago. Speaker: Andrew Whelton, M.D., Johns Hopkins Hosp. CME Credit: 1 hr. AMA Category 1, AAFP. Sponsor, contact: F. Lopez-Fernandez, M.D., Med. Dir., Martha Washington Hosp., 4055 N. Western, Chicago, 60618.

## Obstetrics/Gynecology

### BASIC OBSTETRICS

For: Family Physicians. 1-week course, Dec. 2-6, 1974, Chicago. CME Credit: 35 hrs. AMA Category 1. Fee: \$200. Reg. Limit: 50. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

### SURGICAL & RADIATION THERAPY OF GYNECOLOGICAL MALIGNANCIES

For: Specialists. 1-week course, Dec. 9-13, 1974, Chicago. CME Credit: 30 hrs. AMA Category 1. Fee: \$200. Reg. Limit: 16. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

## Endocrinology

### ADVANCES IN ENDOCRINOLOGY

For: All physicians. Frontiers of Medicine Lecture, Jan. 8, 1975, Billings Hospital, Chicago. CME Credit: 3 hrs. AAFP, AMA Category 1. Fee: \$20. Sponsor, contact: Frontiers of Med., Univ. of Chicago, Box 451, 950 E. 59th St., Chicago, IL 60637.

## Family Medicine

### OFFICE GYNECOLOGY

For: Family Physicians. 5-day course, Jan. 20-24, 1975, Chicago. CME Credit: 32½ hrs. AMA Category 1. Fee: \$175. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

## Ophthalmology

### OCULAR HISTOPLASMOSIS

For: Specialists. 2-day workshop, Jan. 30-31, 1975, Airport Hilton, Indianapolis. CME Credit: 14 hrs. AAFP, AMA Category 1. Fee: \$200. Sponsor, contact: Postgrad. Med. Educ., Indiana Univ. Sch. of Med., 1100 W. Michigan, Indianapolis, IN 46202.

## Psychiatry

### CURRENT & FUTURE PERSPECTIVES IN TREATMENT EVALUATION

For: All physicians. Lecture, Jan. 15, 1975, 7:30 PM, Forest Hosp. Professional Ctr., Des Plaines, Ill. Speaker: T. Kiresuk, Ph.D., Minneapolis. Fee: \$15 (\$5 students). Sponsor, contact: Forest Hospital, 555 Wilson Lane, Des Plaines, IL 60616; (312) 827-8811.

## Stroke in a 19-Year Old Man

(Continued from page 386)

major portion of the thickness of the septum should be excised with the tumor because one doesn't know how deep these run into the septum and if they are shaved off, it can recur.

So, in this case, it was such a simple thing to just take the entire septum out in that area and sew it closed again. The question I would like to ask Dr. Weinberg is, what is going to happen to these aneurysms now since the source of emboli have theoretically been eradicated. Do these aneurysms have the natural history of a congenital aneurysm? Will they rupture? Or, will they fill in with fibrous tissue? We were concerned, of course, that we may have given a shower of emboli when the atrium was opened and the tumor manipulated. It was difficult to enter the atrium because the tumor filled the entire atrium and it was so pliable that just pushing it aside, portions of it would break off. I noted on the filtering screen of the cardiopulmonary bypass, that it was partially covered with tumor tissue. So, I am sure that we did give the patient a shower of micro-emboli of tumor and what is likely to happen to these? The patient is

doing well at present and shows no sign of further central nervous system insults. He is being kept on Dilantin for the time being and he does have a pericardial friction murmur; the etiology of which I am not sure, but I don't think it is very significant.

**Dr. John Beal:** Dr. DeBoer, do you have any information as to the second question that you raised about the fate of the showered emboli?

**Dr. Arthur DeBoer:** No. I do not know what happens to these cells. Perhaps we can ask a few of the authorities present. I understand that these are actually not viable cells that will generate new tumors at the site of the embolus. I can see with such scant cellular structure why it would be unusual. I would guess that tumors would not grow where these cells embolize. I presume they are merely emboli, but I do not understand why they form aneurysms.

**Dr. Peter Weinberg:** Regarding the etiology of the pseudoaneurysms, it was originally suggested that the areas of dilatation resulted from perivascular damage with fibrosis, however the more accepted theory is that the emboli penetrate the endothelium at the site of embolization with subsequent subintimal growth and destruction of the entire wall. ▀



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# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.*

**CAIRO:** FP/CARD/PUL/INT. wanted. Southern Ill. town of 6,500. Several office locations available. Modern community hospital, excellent opportunity for practice, education, public and private schools, Jr. college, and leisure; fishing, hunting, boating. Large cities nearby. Financial arrangements available. Contact COLLECT: Harvey Pettry, Padco Community Hospital, 2020 Cedar St., Cairo 62914 (618-734-2400) (3)

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**HARVARD:** Population 5,200, estimated trading area 20,000. Three physicians at present, previously five. Center of rapidly growing and financially sound area. 65 miles northwest of Chicago, 30 miles east of Rockford. Contact: J. M. Holcomb, Harvard Com. Hosp., Grant & McKinley Sts., Harvard, 60033. (10)

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**MORRIS:** Associate wanted - internist, GP, surgeon; growing general practice near Chicago - population 9,000, lovely clean city. Large new office newly equipped. Hospital close. Attractive financially. Keep

all you earn Share office overhead only. Contact: Dr. V. L. Hicks, Bedford Plaza Center, Morris 60450 (815-942-4067). (1)

**NASHVILLE:** Board certified or eligible surgeon - must be willing to do general practice - 3,000-14,000 - 72 bed JCAH hospital - 50 miles east of St. Louis - excellent schools and churchs - outstanding area to live - assistance available - Contact: T. K. Janssen, 603 South Grand Ave., Nashville 62263 (618-327-8236) (1)

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**PITTSFIELD:** Need family practitioners and surgeons interested in locating in rural community area. Population 4100; area 18,000. Excellent opportunity

for someone wanting to practice in a rural community. Located between Jacksonville and Quincy, on Highway 54 and 36. Contact Dr. T. C. Bunting, Illini Community Hospital, Pittsfield 62363. AC 217-285-2141 or 217-285-2113. (12)

**ROLLING MEADOWS:** Population 20,000. Five physicians at present. 25 miles from Chicago. Loan available to start practice. One mile from 450 bed Northwest Community Hospital. Good office facilities for one or more Family Practitioners, Internists, Pediatricians. Nearby College. Contact: Keith G. Wurtz, M.D., 1430 N. Arlington Hts., Arlington Hts., 60004 (312-255-3313) (1)

**SPRINGFIELD:** Emergency Room Physician, Join 4 permanent staff physicians at a progressive 580 bed general hospital in Central Illinois. Attractive salary and benefits. Enjoy the relaxed atmosphere in this 92,000 population city. Practice medicine without the worries of office employees and accounting. Contact Arthur Lindsay, M.D. Memorial Medical Center, 1st and Miller Streets, Springfield, Illinois 62705. 217-528-2041. (12)

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## Obituaries

\***Borkenhagen, William**, Chicago, died August 6 at the age of 65. He graduated from Chicago Medical School in 1936. Dr. Borkenhagen was a former president of the staff of Christ Community Hospital in Oaklawn.

\***Bruch, Ernest**, Rockford, died July 19, at the age of 69. He graduated from Duke University Medical School in 1937. Dr. Bruch was director of the radioisotope laboratory at St. Anthony Hospital in Rockford.

\*\***Gustafson, J. Eric**, Stockton, died May 21 at the age of 84. He graduated from Hahneman Medical College in 1918. Dr. Gustafson practiced medicine in Stockton for 52 years.

\*\***Martini, Walter**, Springfield, died June 17 at the age of 83. He graduated from Loyola Medical University in 1917. Dr. Martini formerly belonged on the staff of St. Johns Hospital and Memorial Medical Center.

\***Mizock, Joseph**, Chicago, died August 3 at the age of 71. He graduated from the University of Illinois in 1927. Dr. Mizock was on the staff at Walther Memorial Hospital.

\***Moffatt, John**, Rockford, died August 10 at the age of 72. Dr. Moffatt graduated from Rush Medical College in 1931.

\*\***Sachs, Erich**, Chicago, died August 7 at the age of 77. He graduated from the University of Berlin in 1923. Dr. Sachs was a psychotherapist for the last 20 years and he was affiliated with the Alfred Adler Institute of Chicago.

\***Sengson, Peter**, Arlington Heights, died August 4 at the age of 47. He graduated from the University of Stockholm. He was a staff member of St. Elizabeth's and St. Ann's Hospital.

\*Indicates ISMS member

\*\*Indicates ISMS member and Fifty Year Club member

## EKG of the Month

(Continued from page 396)

Answers: 1. E 2. E The rhythm strip shows 2:1 AV block with prolonged PR interval of the conducted P waves. Distinction between Mobitz Type I or II cannot be made with 2:1 conduction since it may be a transient phase in either type. The treatment should include hospitalization, electrocardiographic monitoring, insertion of temporary pacemaker and exclusion of other causes of syncope. If Mobitz Type II block is diagnosed either by demonstration on rhythm strip or bundle of His recordings (showing prolongation of HV conduction) then permanent pacemaker should be inserted. Syncope and arrhythmia are frequently seen with Mobitz Type II block. ▲

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Immediate opening for **Ob-Gyn** and **Internal Medicine**, specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

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**Large physician group has immediate positions available** for full-time or part-time Clinic and Emergency Room work. Several locations in Chicago and Central Illinois. Salary plus liberal benefits average over \$20.00 per hour for full-time work. Scheduling flexible to meet individual needs. Contact Gene Gaertner, M.D., 153 W. Lake, Bloomingdale, Ill. 312-627-3404.

**VACANCY**—Admitting, primary care, personnel physician. Desire physician interested in academic university affiliation, preferably board certified in family practice. Five day week, nites free. VA benefits and retirement. Salary \$26,000 to \$32,000 depending on qualifications. Nondiscrimination in employment. Inquire: Chief of Ambulatory Care, VA Hospital, Iowa City, Iowa 52240. (Phone 319-338-0581).

**PHYSICIAN FOR ACUTE ILLNESS DEPARTMENT** and Emergency Room. Become a part of an expanding, dynamic multispecialty clinic in Midwest university community. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, Illinois 61801. Phone (217) 337-3239.

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**CONTACT:** D. J. Massoglia, Helen Newberry Joy Hospital, Newberry, MI. 49868. Phone (906) 293-5181.

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Internist or family physician to practice in clinic adjacent to hospital. Progressive community. Close to Madison for medical education, referral and social activities. Call or write D. C. Schilling, Administrator, 633 West James Street, Columbus, Wisconsin 53925. Telephone 1-414-623-2200.

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**ILLINOIS:** Position available for fourth **Emergency Physician**. 42 hour average work week. Three weeks vacation and eight days of professional leave at \$50.00 per day. Other fringe benefits. \$21.00 per hour guarantee. 1250 patient visits per month. Summer and winter vacationland near Fox Lake, 60 miles from Chicago, Ill. Applicants contact: Dr. E. H. Sullivan, Attention Administrator's office, McHenry Hospital, 3516 West Waukegan Road, McHenry, Illinois 60050.

Occupational Physicians seeking a challenge with industry: opportunities available for a **Plant Medical Director** and staff positions in our Decatur and Peoria Illinois facilities; competitive salary with excellent fringe benefits; an equal opportunity employer. Contact G. W. Grawey, M.D., Medical Director, Caterpillar Tractor Co., Peoria, Illinois 61629.

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**OFFICE FOR RENT:** Suitable for psychiatrist or psychotherapist. Contact: Dr. Gamm, c/o C. Swartz, 532 Pleasant, Highland Park, Ill., 60035, 433-0819, or call Ans. Serv. at (312) 787-7480. @ \$150/mo. located at 664 N. Michigan Ave., Chicago.

**VACATION ON SANIBEL ISLAND, FLORIDA.** Luxurious condominium on Gulf Beach; two bedrooms, two baths, sleeps six; air-conditioned, pool, porch; minimum rental one week. Box 194, Ann Arbor, Michigan 48108.

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# BLUE SHIELD REPORT

## FOR Illinois Physicians



### Comprehensive Major Medical—A New Approach

Our Plans are constantly seeking new ways of improving health care protection. The most recently designed health care programs of the Illinois Blue Cross and Blue Shield Plans are our Comprehensive Major Medical programs.

Written to incorporate long range Major Medical protection with a broad scope of basic benefits, these programs are now a standard offering to groups in Illinois. Comprehensive Major Medical contracts can be identified by the group numbers assigned—75000 series.

A special Claims Department will handle contract benefits and administrative services to the groups, and the traditionally separated functions of Blue Cross, Blue Shield and Major Medical are in fact merged in meeting the service requirements of these new contracts.

By design, basic Blue Cross and Blue Shield certificates have been traditionally written as "first dollar" coverage for health care protection. The effect has been immediate financial relief for our members and the reimbursement of hospitals and physicians who file claims for services rendered.

With the introduction of Major Medical coverage that broadened the scope of health care benefits, the concepts of deductibles and coinsurance were applied so that catastrophic medical bills could be insured at reasonable group rates. These variable features as well as the dollar maximum amounts were employed in writing appealing coverage for the group market requirements.

Initially, basic "first dollar" coverage and Major Medical coverage existed side-by-side but functioned separately, Major Medical being supplemental to the others. Major Medical benefits were written to apply *after* basic coverage, which was actually Major Medical's deductible. As medical expenses increased, basic indemnity payment values diminished and more companies began to consider the coinsurance features of Major Medical which provided payments of more charges *not covered* by the limited basic programs. Even though the Usual and Customary type of payment is now utilized for full coverage of basic benefits by many groups, the Major Medical formula is relied upon to provide adequate reimbursement for services *outside* the scope of basic contracts.

Since the total cost of *full* coverage of medically-related services is virtually out of reach of most

purchasers of health care, a trend to balance values within a *range of services* led to variations of coverage written into contracts (e.g. obstetrical, outpatient services, mental illness, etc.).

#### Total Health Care Expenses Considered

Thus many groups will now determine in what areas they will provide "first-dollar" care, where deductibles will apply, when coinsurance will be utilized, and in each instance, how much. In effect, the total health care bill to the patient during various stages of illness is considered, whether it is for a hospital room, physician's visits, or laboratory tests.

Under the Comprehensive Major Medical program a broad scope of professional services is covered because the combined benefits are written to a group's specifications. When a service is furnished to a member of a Comprehensive Major Medical Group, please complete a Blue Shield Physician's Service Report and use the group numbers assigned in the 75000 series.

#### U.S. Postal Service to Discontinue Unpaid Mail Delivery

Effective November 17, 1974 the U.S. Postal Service will discontinue delivery of unpaid mail, a recent announcement from Postmaster General E. T. Klassen stated. Mail without postage will be returned to the sender, *provided the mailing piece has a return address*. Previously unpaid mail was generally delivered on a postage due basis.

Mail matter of any class, received at either the office of mailing or the office of the addressee without postage, will be endorsed "returned for postage" and returned to the sender. No attempt will be made to collect postage due.

If the envelope *does not* contain a return address, it will be sent to the dead letter office for appropriate handling. Postage due delivery has caused severe financial loss for utility, business and professional establishments with the volume of unpaid mail increasing, the release stated.

## ASK BLUE SHIELD

... ABOUT MEDICARE

### LIMITATION ON LIABILITY OF BENEFICIARY AND PHYSICIAN—(Part II)

Part II of the summary of a new section of the Medicare Act entitled "Limitation on Liability of Beneficiary and Physician" follows. It describes notification of denial of payments of claims by the Part B Medicare carrier under the waiver provision, and the procedures of review and hearing.

Part I of the summary, published in October issue of "Ask Blue Shield About Medicare", Illinois Medical Journal described the three basic aspects of Section 1879 of the Medicare Act concerning the Waiver of Liability Provision which determine whether (in assigned claims after October 1972) liability of a beneficiary may be limited or waived in Part B denial cases involving services of physicians or suppliers, or that of the physician or supplier; and the determination of services considered "not reasonable and necessary or custodial".

The concluding portion of the summary will be published in December issue of "Ask Blue Shield About Medicare" and include the sections on (1) When Program Payments Can be Made, (2) Indemnification, and (3) Procedures that Apply to the Retroactive Period.

#### III. Notification of Denial by the Carrier

When a denial is made for services not considered reasonable or necessary by the carrier, which were furnished under an assignment agreement after October 30, 1972, the carrier will insert a statement in the Explanation of Medicare Benefits notice (EOMB) or in a denial letter, *in addition* to the pre-printed notice of the right to review of the case. It will state:

"If you did not know that Medicare does not pay for this medical service for this condition, you may request a review of this decision. (See item 6 on the back of this form.)"

If a disallowance letter is used in place of the EOMB, the carrier includes this statement, and in the case of a summary voucher, the voucher will indicate which items and services could be considered for waiver of liability of payment.

#### IV. The Procedures of Review and Hearing

The Part B carrier *does not* determine liability for payment of services of supplies *until the time of review*; nor is the issue of liability considered by the carrier at the time the claim is processed.

When a review is requested following denial of a claim under the waiver provision, it will consist of two stages: (1) Examination of the facts regarding the *coverage issue* to determine whether the review is appropriate, and (2) arrival at a decision whether to waive liability of beneficiary and, if so, that of the physician or supplier, thus resulting in exemption for both and payment of the claim by the Medicare program.

The review to determine liability involves beneficiary and physician or other supplier. First the determination is made whether the beneficiary (or his representative) knew or could have been expected to know that the services would not be covered. If it is found the beneficiary is liable, the

physician or supplier can seek payment. If the beneficiary is exempted, the determination of liability or waiver is made for the physician or supplier. If either of the parties are declared liable, *they may not seek payment from the beneficiary*. Only when the review determines that parties to the assignment agreement *are exempt* under conditions of the waiver of liability provisions, will Medicare make payment of the denied claim.

Reviews are conducted at the request of either party, although frequently a request may be received from only one party. Notification, however, is made to both parties by the carrier that a review has been requested.

Carriers will protect the rights of both parties in assuring them of their opportunity to request a hearing.

In the hearing process, a beneficiary's allegation that he could not have been expected to know that services or items he received were not reasonable and necessary will be acceptable evidence for waiver unless *there is evidence to disprove the allegation*. An example would be of a beneficiary receiving a course of treatment for which he had already received a denial notice from the carrier that the services were not covered. The denial notice would constitute evidence that the beneficiary had knowledge the service was non-covered.

To a degree, the same principle applies to the review of the physician or other supplier. His allegation that he did not know nor could be expected to know that the service or item was non-covered will be acceptable for waiver of liability *in absence of contrary evidence*. Evidence considered contrary would be:

- (1) The carrier provided general notice to the medical community regarding non-coverage of certain services, e.g. acupuncture.
- (2) The carrier provided general notice to the medical community that services exceeding certain frequencies would be denied or subject to additional reviews; e.g. vitamin B<sub>12</sub> injections or nursing home visits more than once a month.
- (3) The carrier had given written notice to the particular physician or supplier that a type of service or item would not be covered in all or certain circumstances; or
- (4) The carrier had given previous written notice to the physician or supplier that a course or type of treatment for a particular beneficiary's diagnosis would not be covered.

A pattern of unnecessary services by a physician or supplier to a number of beneficiaries, when it is reasonable to expect that he would know, because of expertise in his field of work that such a pattern deviates from standard practice, would imply knowledge of non-coverage. The liability of the beneficiary may be waived in these situations.

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# Editorials



## *Intestinal Shunting for Morbid Obesity*

**I**ntestinal bypass is, perhaps, one of the most extreme treatments for morbid obesity. It is 90% effective despite the risk of uncontrollable diarrhea and electrolyte imbalance. The patients must be carefully selected, and the surgeon frequently requires evidence that the person has tried repeatedly to diet, or that the person has had a long record of intermittently successful weight loss interspersed with periods of ever-greater weight gain.

The risks attending anti-obesity surgery must also be balanced against the dangers of certain complications of obesity such as diabetes, arthritis, hypertension, and the Pickwickian syndrome.

Morbid obesity usually means that the person weighs 100 or more pounds too many. It also is defined as a weight that is two or three times the patient's ideal weight. Weight in itself is not the sole indication for bypass surgery.

Justifications for the anti-obesity operation are: 1) the person has been extremely obese for at least 5 years; 2) he is otherwise healthy and not an alcoholic. Alcoholism increases the risk of surgery because the liver is liable to damage from intestinal bypass procedures. In addition, alcoholics neglect follow-up care and view the operation as a panacea for all their problems.

Various intestinal shunting operations are done, as there seems to be no agreement as to what part and how much of the small intestine should be bypassed. One of the most popular procedures bypasses most of the small bowel, retaining short lengths of both jejunum and ileum in continuity and joining them thru end-to-end jejunoileostomy. No reoperation is planned.

Authorities are not in agreement as to how much of the small bowel should remain in continuity. As a rule, from 20 to 30 inches are left for adequate absorption.

Similar results also can be obtained by bypassing 90% of the stomach. Reducing the size of the stomach usually causes early satiety and lessens the desire for enormous amounts of food. More needs to be known about this method, although the approach appears to have as much merit as introducing malabsorption downstream.

The results of jejunoileal bypass are good, as the average patient loses about one-fifth of his initial weight in the first six months, and one-third by the end of the year.

The 4% mortality rate is tolerable if persistent massive obesity is a threat to life. Fecal fat, serum carotene, and D-xylose absorption are normal after the operation. Diarrhea subsides after a few months. However, episodic diarrhea can provoke serious hypokalemia, hypomagnesemia, and hypocalcemia. Multiple vitamin preparations are usually given thereafter.

Polyarthritides is, perhaps, the most unusual complication whereas the adverse effects on liver function are the most serious and perplexing. Fatty infiltration among the obese is well-known, but small bowel bypass increases it. In fact, deaths from this cause have been reported.

In other words, intestinal shunting can be risky and should be undertaken only in adults, when all other methods have failed and obesity is an imminent threat to life.

*T. R. Van Dellen, M.D.  
Editor*

# When diarrhea wrings the wedding belle...

It's all very well to counsel patience in diarrhea patients. There are times when relief of symptoms can't come too soon.

X-ray studies<sup>1</sup> in 16 normal subjects showed just how promptly the active ingredient in Lomotil does its work.

Lomotil retarded gastrointestinal motility particularly during the first three hours after administration. It continued its moderating action on the bowel for at least three hours more.

Physicians prescribe Lomotil more often than any other drug when the urgency for the control of diarrhea is most distressing.

1. Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroenterol Belg. 21:674-680 (Sept.-Oct.) 1958.



# Lomotil®

**TABLETS/LIQUID**

Each tablet and each 5 ml. of liquid contain:  
diphenoxylate hydrochloride . . . 2.5 mg.  
(Warning: May be habit-forming)  
atropine sulfate . . . . . 0.025 mg.

## Saves the Day

# **Abstracts of Board Actions**

**October 12-13, 1974**

**Carbondale**

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.*

## **House of Delegates Special Session**

The Board of Trustees called a special session of the House of Delegates to reassess the position of ISMS in all matters regarding professional standards review. The meeting will open at 1 p.m. Saturday, November 9, and continue through Sunday at the McCormick Place Inn in Chicago.

In preparation for the meeting, a tabulation and analysis of the PSRO membership survey will be mailed to all delegates and alternates along with an unbiased historical report on what ISMS has done — and where the society stands at this point on the PSRO issue.

## **Resolutions For AMA House of Delegates**

The Board requested the ISMS delegation to introduce six resolutions that would urge AMA to:

- A. Oppose the use of HCG in weight control therapy until its efficacy in this field has been clearly proven; and develop a public education program on potential dangers of HCG therapy in weight control.
- B. Utilize the legislative capabilities of state medical societies in major national health legislation, such as HR 16204.
- C. Support creation of an agency to catalogue potentially hazardous substances now being transported or stored in the U.S.
- D. Call upon Blue Cross plans to eliminate "cost-plus-five percent" reimbursement contracts with ambulatory surgical care facilities and encourage state medical societies to initiate legislation prohibiting use of the "cost plus" concept.
- E. Support a new method for selection of members of the AMPAC Board of Directors.
- F. Establish a state medical society Key-Man Program on national legislation, organized through the 12 AMA field regions. The regional groups would elect a chairman who would sit on a national panel composed of the 12 regional representatives.

## **Move to New Building**

The Board authorized an unbudgeted expenditure of \$45,682 to cover the added cost involved in moving the society's headquarters — along with the Illinois Foundation for Medical Care and the Illinois Council for Continuing Medical Education — to the Mid-Continental Plaza at 55 E. Monroe Street, Chicago. The added expenditure, necessitated by changes in construction plans will be taken from the \$55,175 presently budgeted for the Permanent Reserves in 1974.

## **Joint Meeting With IHA**

The Board authorized ISMS to join forces with the Illinois Hospital Association in attacking two common problems: (1) the controversy surrounding revisions of hospital medical staff bylaws; and (2) inadequacies of IDPA reimbursements to health care providers. The ISMS Hospital Relations Committee will explore the feasibility of co-sponsoring with IHA a Conference on Medical Staff By Laws in 1975 and the ISMS Executive Committee will work with IHA in developing a Blue Ribbon Task Force to study the problems facing health care providers participating in publicly-financed health programs. The task force

*(Continued on page 492)*

# Sign of a cold sufferer

## Time for Ornade®

Each Spansule® capsule contains 8 mg. Teldrin®  
(brand of chlorpheniramine maleate);  
50 mg. phenylpropanolamine hydrochloride;  
2.5 mg. isopropamide, as the iodide.

Fast relief of upper respiratory congestion  
and hypersecretion\*  
with convenient b.i.d. dosage.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

\* **Indications**

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Possibly effective: For relief of upper respiratory tract congestion and hypersecretion associated with vasomotor rhinitis and allergic rhinitis, and for prolonged relief.

Lacking in substantial evidence of effectiveness: For relief of nasal congestion and hypersecretion associated with the common cold and sinusitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

**Warnings:** Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

**Usage in Pregnancy:** In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

**Effect on PBI Determination and  $I^{131}$  Uptake:** Isopropamide iodide may alter PBI test results and will suppress  $I^{131}$  uptake. Substitute thyroid tests unaffected by exogenous iodides.

**Precautions:** Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

**Adverse Reactions:** Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

**Supplied:** Bottles of 50 capsules; in Single Unit Packages of 100 (intended for institutional use only).

**Smith Kline & French Laboratories**

Division of SmithKline Corporation,  
Philadelphia, Pa. 19101



## Clinics for Crippled Children Listed for December

### new Catapres® (clonidine hydrochloride)

Tablets of 0.1 mg and 0.2 mg

**Indication:** The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

**Warnings:** Tolerance may develop in some patients necessitating a reevaluation of therapy.

**Usage in Pregnancy:** In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

**Usage in Children:** No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

**Precautions:** When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phenotolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres, in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

**Adverse Reactions:** The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorothalidone and papaverine hydrochloride.

Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritis not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

**Overdosage:** Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analgesic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres (clonidine hydrochloride) overdosage.

**How Supplied:** Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.  
Under license from Boehringer Ingelheim GmbH

**Reference:** 1. Onesti, G. et al.: Pharmacodynamic effects of a new antihypertensive drug, Catapres (ST-155). Circulation 39:219, 1969.

Twenty-six clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 18 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

|          |    |  |
|----------|----|--|
| December | 3  | Belleville—St. Elizabeth's Hospital                                    |
| December | 4  | Rock Island Cerebral Palsy—Foundation for crippled Children and Adults |
| December | 4  | Hinsdale—Hinsdale Sanitarium   |
| December | 5  | Sterling—Sterling Community Hospital                                   |
| December | 5  | Springfield—St. John's Hospital  |
| December | 5  | DuQuoin—First Methodist Church   |
| December | 5  | Lake County Cardiac—Victory Memorial Hospital                          |
| December | 9  | Peoria Cardiac—St. Francis Children's Hospital                         |
| December | 10 | Peoria—St. Francis Children's Hospital                                 |
| December | 10 | East St. Louis—Christian Welfare Hospital                              |
| December | 10 | Carmi—Carmi Township Hospital  |
| December | 11 | Champaign-Urbana—McKinley Hospital                                     |
| December | 11 | Springfield Pediatric Neurology—Diocesan Center                        |
| December | 12 | Litchfield—St. Francis Hospital  |
| December | 12 | Kankakee—St. Mary's Hospital   |
| December | 13 | Chicago Heights Cardiac—St. James Hospital                             |
| December | 16 | Peoria Cardiac—St. Francis Children's Hospital                         |
| December | 17 | Peoria—St. Francis Children's Hospital                                 |
| December | 17 | Rock Island—Moline Public Hospital                                     |
| December | 18 | Aurora—St. Joseph Mercy Hospital                                       |
| December | 18 | Chicago Heights—St. James Hospital                                     |
| December | 19 | Rockford Memorial Hospital   |
| December | 19 | Bloomington—Mennonite Hospital   |
| December | 19 | Elmhurst Cardiac—Memorial Hospital of DuPage County                    |
| December | 27 | Evanston—St. Francis Hospital  |
| December | 27 | Chicago Heights Cardiac—St. James Hospital                             |

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on behalf of crippled children. □



# House Staff Organizations

BY KONG MENG TAN, M.D. AND MICHAEL HUGHEY, M.D.

*The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.*

Nearly four years have passed since the first stirrings of housestaff activism at the First National House Staff Conference in St. Louis in 1971. Since that time, much has been accomplished. The Physicians National House Staff Association (PNHA), an independent national grouping of housestaff associations, has become a reality. It has acquired a dynamic young Executive Director and has recently been awarded an HEW grant to promote the National Health Service Corps.

Within the AMA, housestaff appointments to many important councils and committees have been made. The Committee on House Staff Affairs, consisting entirely of house officers, reports directly to the AMA Board of Trustees on issue-oriented items of its choice. There are joint PNHA-AMA representatives on the National Board of Medical Examiners, the Educational Council on Foreign Medical Graduates, and the Liaison Committee on Graduate Medical Education. Housestaff physicians are actively participating on Congressional studies on the house officer, run by the Institute of Medicine.

Guidelines for housestaff contracts have been drafted. While these guidelines have aroused a great deal of controversy within the medical profession, they have been thoughtfully and intelligently discussed. Representative cases of lack of due process involving housestaff have been brought to the attention of the AMA and the medical press and guidelines for due process have been written to be included in the *Essentials of Approved Residencies and Internships*.

The Committee on Housestaff Affairs has issued an extensive report on foreign medical graduates calling for the elimination of discriminatory practices against FMG's, the report containing nearly 45 recommendations. Housestaff are concerned about residency review policies. They are concerned about national legislative policies affecting the health environment and some of the pernicious policies in the GAP report (see *IMJ*, May, 1974).

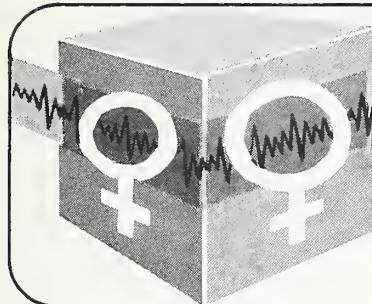
Several large and small housestaff organiza-

tions already have become nationally prominent, including: the Committee on Interns and Residents of New York City, representing approximately 5,000 house officers; the Mayo Clinic Fellows Association; the Cook County Hospital Residents and Interns Association, the University of Michigan Housestaff Association which had to report to the Michigan Supreme Court in order to achieve bargaining status; and the Los Angeles County Housestaff Association, which is the only housestaff group in the nation to be awarded a PSRO planning grant.

There is a need for still more involvement. More hospitals need organized housestaff associations. There is opportunity for housestaff representation on medical staff and hospital committees. As the practitioners of medicine for the immediate future, housestaff need to participate actively in planning of the health care system. *To do this, house officers must be included in policy and decision making at every level of health care delivery.* Guidelines for housestaff contracts and due process disputes should be available soon. They need to be implemented at the local level. Unless there are strong housestaff organizations that can sit down and negotiate capably with their administrations, these guidelines will remain nothing more than suggestions.

Serious disputes involving due process need to be aired. House officers have been summarily dismissed from their residencies without any form of hearing or any reason stipulated. Some have been employed solely to perform routine "scut work" with only token educational value. House officers have been dismissed from their residencies because they were paid for providing medical care in their off-duty hours to patients who needed help. House officers have been denied listings of laboratory charges by hospitals who maintained that the cost of a lab test was unimportant or deleterious to the house officer's education. House officers have been asked to "voluntarily" resign with the threat that if they resist, they will "never become board certified."

(Continued on page 478)



## pulse... of the doctor's wife

MRS. HAROLD KEEGAN, Editor

# Bureau County Medical Auxiliary Celebrates 40 Years

The Woman's Auxiliary to Bureau County Medical Society celebrated its 40th anniversary at a luncheon held September 24th at the Princeton Country Club. Mrs. Thomas Glatter and Mrs. Eugene Vickery, State Auxiliary President and President-elect respectively, attended the recognition luncheon.

The County's organization came about April 10, 1934, at a dinner meeting held at the Clark Hotel in Princeton. Of the seventeen charter members, seven are still living. Charter members were:

Mrs. C. R. Bates, DePue  
Mrs. H. E. Brown, Tiskilwa  
Mrs. R. E. Davies, Spring Valley  
Mrs. H. B. Dunn, Granville  
Mrs. O. J. Flint, Princeton  
Mrs. O. B. Giltner, Sheffield  
Mrs. C. J. Green, Ladd  
Mrs. Richard Herrick, Wyanet  
Mrs. J. H. Hopkins, Walnut  
Mrs. T. S. Huggard, Oglesby  
Mrs. G. S. McShane, Spring Valley  
Mrs. R. E. Milenberger, Spring Valley  
Mrs. G. C. Nelson, Wyanet  
Mrs. K. M. Nelson, Princeton  
Mrs. M. A. Nix, Princeton  
Mrs. C. A. Smart, Granville  
Mrs. L. H. Wiman, LaMoille

In 1943 Bureau County was specially honored when Mrs. M. A. Nix was installed in Chicago as State Auxiliary President.

The Auxiliary met monthly on the same date as the Medical Society. Alternating between Perry Memorial Hospital, Princeton, and St. Margaret's Hospital, Spring Valley. The follow-

ing were and are the Auxiliary's objectives:

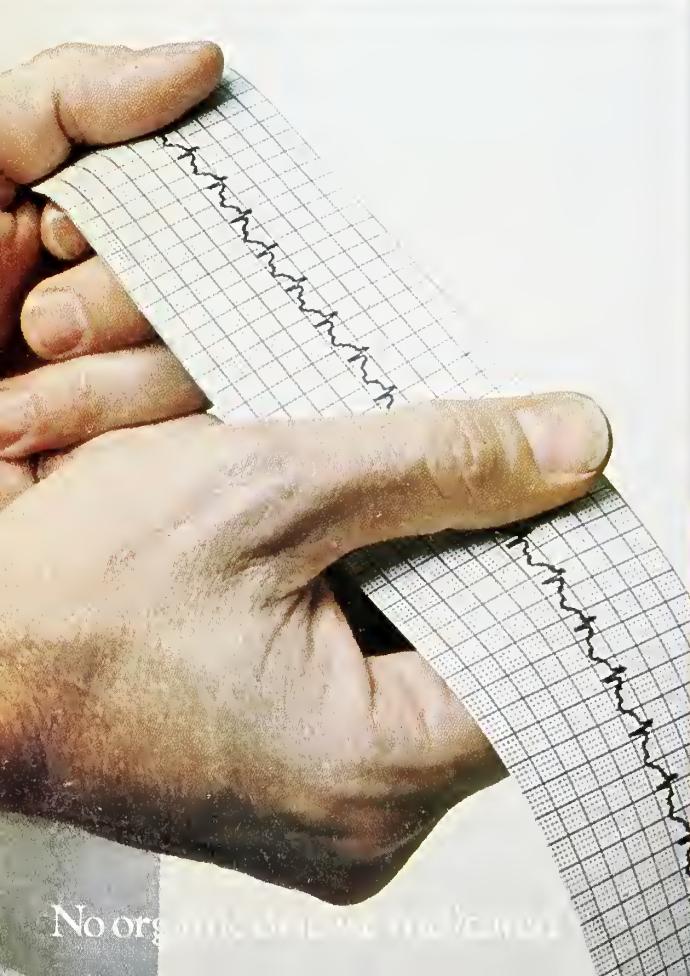
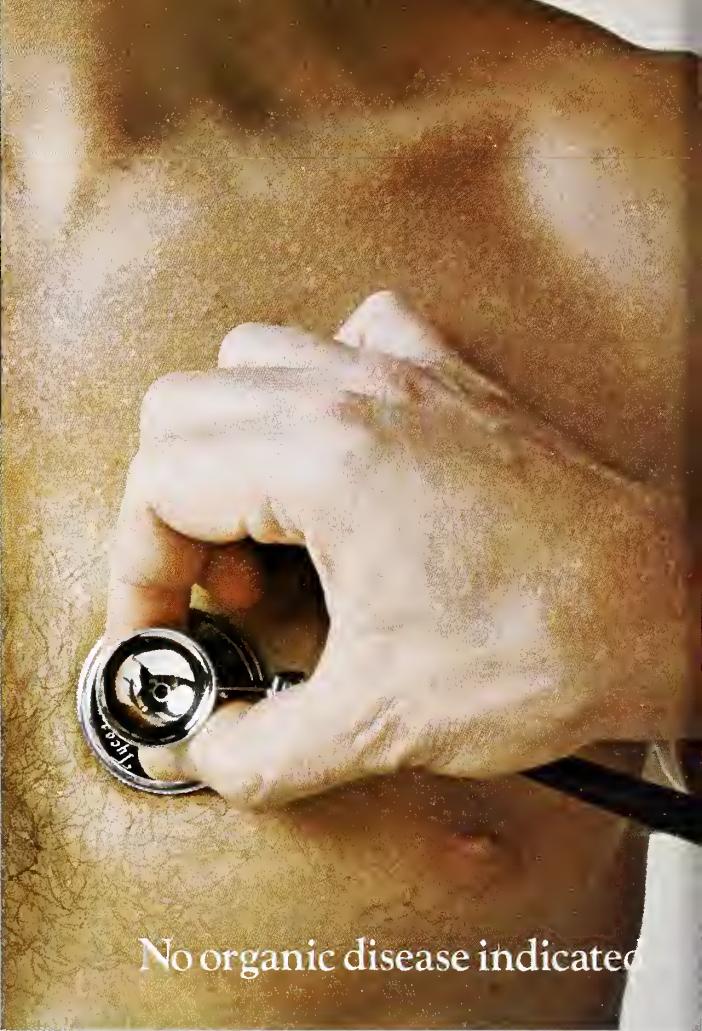
1. To assist the Medical Society in the advancement of the prevention of disease.
2. To aid in securing better medical legislation.
3. To participate in such supplemental work as was determined from time to time by the Medical Society.
4. To contribute to the Medical Benevolence Fund.

The initial enthusiasm of the Auxiliary centered on health problems of the times thru volunteer projects at the school, county fair, and the hospitals. During World War II many doctors entered military service and the activities were geared to patriotic efforts such as "The Victory Book Campaign," donations of money and volunteer hours to the Red Cross and Bond Drives.

Post-war saw other changes. *Today's Health* subscriptions were presented to all the schools. Also, a major program was the establishment of a "Nurse Student Fund," which still exists.

In 1963, the Auxiliary decided to meet socially and dispense with the formal portion of the meetings. However, it was agreed to continue the Nurse Student Fund, and each member was requested to make payment of her annual dues and a contribution to help maintain the Fund. Most of the women were active members of their local Hospital Auxiliary and other civic and community groups. Some continue to take a very active part. There has been some interest recently to resume the formal part of the meetings.

CONGRATULATIONS BUREAU COUNTY MEDICAL AUXILIARY!





# *medical legal review*

## *Medical Malpractice: Viewpoint of a Plaintiff's Attorney*

BY J. B. SPENCE, PARTNER  
SPENCE, PAYNE & MASINGTON, P.A.

As an attorney who specializes in medical malpractice litigation, I have formed opinions which I have had occasion to present to the staffs of hospitals, medical conventions, and other interested groups.

I am offered two or three malpractice cases every day. This tells me that there is a substantial loss of rapport between the medical community and its patients.

*Why are so many patients going to lawyers?*

*Why are so many malpractice cases being filed?*

*Why are so many malpractice cases being tried?*

*Why are juries frequently returning verdicts in excess of \$1 million in medical malpractice cases in the U.S.?*

The answers, in my opinion, have to do with the thinking of the medical community, the companies which write medical malpractice insurance and the defense lawyers who represent these insurance companies.

No one thinks settlement. The insurance attorney makes a substantial fee defending the case. Frequently, his motivation is to advise the doctor or the hospital that the defendant has a substantial chance to win the case. The doctor wants to hear this; so does the hospital administrator. The defendant always seems to want to justify what he did. Anger over being sued often clouds judgment.

For decades in America the plaintiff virtually could not win a medical malpractice case. This was wrong, unjust and unfair. The law is often slow to change or adjust, but in this type of litigation the legal pendulum is moving. The

law in most states now comes close to being fair to both sides in a case.

This has occurred because plaintiffs' lawyers across America almost in unison decided to fight back. Cases were taken and tried, and old rules have changed.

Our position is thus: If you run a stop sign and it's your fault and you hurt someone, why should you get up tight about paying for it? Or, if you are medically careless and run a medical stop sign, why should you not pay for it?

If the medical community refuses to negotiate and settle by being lulled into a feeling of self-righteousness by defense attorneys, we are going to continue to have the world of malpractice litigation in which we presently live.

Jurors no longer are as sympathetic with doctors and hospitals. Jurors now come to the jury box with some prejudice about waiting in a doctor's office for two hours before being seen; about being ignored while urgently ringing the bell in the hospital to get a nurse's attention; about being overcharged; about being treated like cattle. Simply put, the chickens are coming home to roost.

Kind, gentle care; punctuality, human understanding, a real "visit" with the doctor, are among the hundreds of thoughtful ways to re-establish rapport between patients and the medical community and to wipe out a substantial percentage of malpractice allegations and claims. □

### **Reprinted from:**

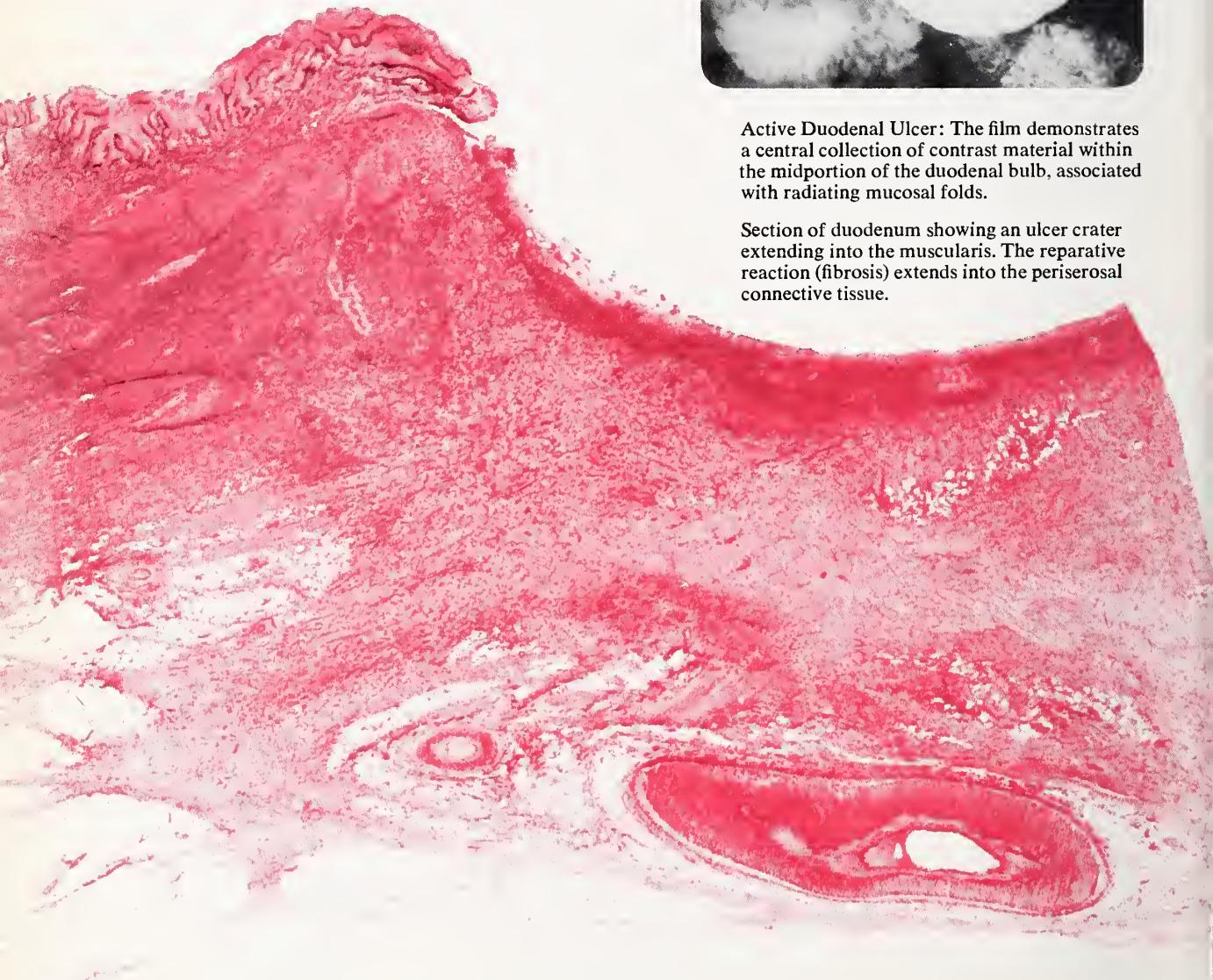
"*Malpractice Digest*," Professional Liability Risk Management Department, St. Paul Fire and Marine Insurance Company, St. Paul, Minnesota, Mar.-Apr. 1974, p. 1.

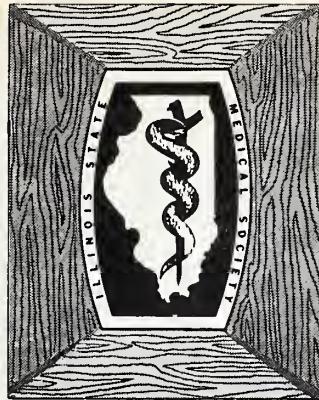
# Status Symbol



**Active Duodenal Ulcer:** The film demonstrates a central collection of contrast material within the midportion of the duodenal bulb, associated with radiating mucosal folds.

Section of duodenum showing an ulcer crater extending into the muscularis. The reparative reaction (fibrosis) extends into the periserosal connective tissue.





# IMJ

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## A Children's Hospital in Chicago, 1882-1904

BY RONALD D. GREENWOOD, M.D./BOSTON, MASS.

Bringing a hospital into existence in the mid-19th century was an arduous task. And, after it was in existence, extraordinary measures were necessary to keep it alive. This was especially true of hospitals devoted to children.

Pediatrics was at this time virtually nonexistent in the United States. Abraham Jacobi (1830-1919) arrived in this country in October, 1853, after spending several years in German prisons for revolutionary activities. He settled in New York and became the "Father of American Pediatrics," and the "founder of the specialty of the diseases of children." Jacobi taught Pediatrics in New York from 1857 until 1899, and except for J. Lewis Smith (1827-97) was the only American physician who practiced or taught pediatrics at that time.

Shortly after Jacobi's arrival on this continent, The Child's Hospital and Nursery was organized on March 1, 1854. This was the first hospital devoted to children in this country, although it also was a maternity hospital in its early years. One year later, in 1855, The Children's Hospital of Philadelphia, the first hospital designed exclusively for children, opened its doors.

In a country with high childhood mortality and overcrowded, unsanitary general hospitals, it might be expected that other hospitals, especially for children, would follow the first two. This, however, was not the case.

As the war between the States was drawing to a close, the Chicago Hospital for Women and Children was founded in 1865. This has incorrectly been said to be the first children's hospital in America. It was neither the first, nor was it just for children. The hospital was founded by Dr. Mary Harris Thompson for the care of "women and children of the respectable poor" and had a capacity of fourteen patients. The hos-

pital was primarily for widows and orphans of civil war veterans. When Dr. Thompson died in 1895, the hospital was renamed The Mary Thompson Hospital.

In 1882 Chicago received its first hospital exclusively for children. A middle-aged Chicago woman whose son had succumbed to illness in late childhood recognized the need for a hospital devoted exclusively to children, and she founded and operated the small charity hospital which would eventually become Children's Memorial Hospital. The woman was Mrs. Julia F. Porter, the wife of Reverend Edward C. Porter, an Episcopal Rector of Chicago. Her father, Dr. John H. Foster, was a New Hampshire surgeon.

The year was 1882. Mrs. Porter planned an all charity hospital for children. The physical plant began as a small frame house on the southeast corner of Halsted Street and Belden Avenue, and was named The Maurice Porter Memorial Hospital for Children. The house was a three story building and was equipped as a hospital with accommodations for 6 beds at a cost of \$13,000. To aid her in running the hospital, Mrs. Porter chose a Miss Calneck as the first matron. Miss Calneck was not a nurse, but had been associated with an Episcopal institution and there had obtained extensive experience in nursing. She received the stately salary of \$30.00 per month, and was given funds for two assistants, each to receive \$18.00 per month. One of these assistants was Miss Fanny Baldwin who was associated with the hospital for 13 years (1882-1895). The physician who was in charge was Dr. Truman W. Miller, a surgeon. He remained associated with the hospital as doctor in charge and president of the small medical staff, until his death in 1900. During 1883, the hospital's maintenance cost was slightly over \$2,000, an amount ample to support a daily patient census of four to five.

The physical plant was small, and the need for larger, better facilities was recognized early. In 1883, land on the northwest corner of Fullerton Avenue and Orchard Street was purchased at a cost of \$7,950. The staff needed improve-

RONALD D. GREENWOOD, M.D., is a Fellow in Pediatrics, Harvard Medical School and Fellow in Cardiology, Children's Hospital Medical Center, Boston, Mass. At the time of writing this article, Dr. Greenwood was serving as a Captain, U.S. Army, Irwin Army Hospital, Ft. Riley, Kansas. Dr. Greenwood graduated from Northwestern University Medical School and has co-authored numerous articles on diabetes mellitus.



Dr. Truman W. Miller's Surgical Clinic,  
Maurice Porter Hospital.



A Smiling Face of 1974



One of the Patients in 1974



Christmas Party at Children's Memorial Hospital, 1934



Children's Memorial Hospital Rummage Shop



1974—Photography by Mike Ahearn

Archive pictures courtesy of Children's Memorial Hospital, Chicago.

ment also. In the next year, 1884, Miss Genevieve Gilmore was appointed as matron of the hospital. Miss Gilmore, unlike the first matron, was a nurse—a graduate of the first class of the Illinois Training School for nurses. Miss Gilmore remained until 1887.

The need for a more spacious and better equipped physical plant became overwhelming, so in 1886, Mrs. Porter erected a building on the property at Fullerton and Orchard. This three story brick structure housed 20 beds.

When Miss Gilmore resigned in 1887, Miss Headline, also a graduate of the Illinois Training School, became the third matron and was given three assistants. When she left in 1889, a Mrs. Eby served as interim matron for seven months until Miss Lillian O'Connor, a graduate of the Orange Memorial Hospital Training School of Orange, New Jersey, was brought in to be matron. The position of matron had quite a turnover in these early years. In 1891 a Miss Coulter replaced Miss O'Connor and in 1893, Miss Jane H. Pollocks became matron. In the early days of a very small hospital with a part time medical staff, the position of matron was indeed important.

### Board of Managers Organized

The hospital's services were increasing and its administration demanding. From 1882 until 1891, the total number of patients cared for was 232. During 1892 there were 68 patients. By 1893, the increasing load of the hospital and the decreasing stamina of Mrs. Porter led her to re-organize the administration of the hospital and organize a Board of Managers. This Board consisted of many of Mrs. Porter's friends who were interested in the work she had started.

The Board members were as follows:

|                      |                       |
|----------------------|-----------------------|
| Mrs. Julia F. Porter | Mrs. Samuel G. Taylor |
| Mrs. Joseph T. Bowen | Mrs. George E. Adams  |
| Mrs. A. C. McClurg   | Mrs. Orsen Smith      |
| Mrs. Henry Field     | Mrs. Mahlon Ogden     |
| Mrs. E. R. Mead      | Mrs. Robert North     |

Mrs. Joseph T. Bowen first began her association with the hospital in 1893. A friend of Mrs. Bowen's, Harriett Smith, asked her if she knew Mrs. Julia Porter. The answer was no. Mrs. Smith then explained that she had been sent to ask Mrs. Bowen to be president of the Porter Hospital. Mrs. Bowen was interested and made a trip to the hospital, and she recalls:

I . . . found it an old house of brick, I think, facing south, rather dingy looking, with some grounds around it. The rooms were large and would hold several beds or cribs. There was a small staff of nurses.

Mrs. Bowen then went to visit Mrs. Porter. She continues:

She lived three or four blocks from the hospital. When I was admitted she was sitting on a sofa and looked like a very severe old lady. She spoke to me, asked me right away if I would be president of the hospital. She had a Board, but needed more people on it. I replied that I would accept if I could have her interest and be supplied with certain necessities which I had not found in the hospital when I visited it.

But Mrs. Porter was not liberal with her funds, nor was she easy to deal with.

Mrs. Porter's idea of a hospital apparently was a large house: When I went to her on one occasion and said we must have linen, there were not sheets enough to change the cribs, and we must have a great number of wash cloths. Her reply was that she thought one wash cloth should be passed around—all the children washed with that one, it could be washed out between baths. I told her this would not do at all and I would have to be given permission to purchase and charge to her such linen as I thought was necessary and that I would take someone from the Board of the hospital with me when I shopped.

Despite these problems, Mrs. Bowen went to work and guided the hospital along.

In 1894, Mrs. McClurg, Mrs. Field, and Mrs. Smith resigned from the Board and Mrs. E. B. McCagg and Mrs. Bryan Lathrop were appointed.

In 1894, a training school for nurses was begun; this continued until 1900 and produced ten graduates.

The hospital was incorporated March 27, 1894, and seven people were appointed to the Board of Directors. They were Mrs. Orson Smith, Mr. Bryan Lathrop, Mr. George E. Adams, Mr. James W. Porter, Mr. C. Normal Fay, Mr. A. C. McClurg, and Mrs. Julia F. Porter. The men of the Board were the first other than physicians to enter Mrs. Porter's venture. This Board appointed annually a Board of Lady Managers (Board of Managers mentioned previously.)

In 1895, another new nurse was appointed matron; she was Miss Catherine Hewitt and who served until 1899.

In the same year the hospital was further enlarged by an addition to the original building at a cost of \$6,000. This addition provided one large ward, a number of much needed private rooms for nurses and special cases, and a large bathroom. This addition enlarged the bed capacity to between 40 and 50 patients. Mrs. Bowen was instrumental in building this addition and furnishing it. Through the generosity of Mrs. Bowen and Mrs. Lathrop, a kindergarten was begun. This same year the age limit for admis-

sion was expanded from 3-13 to 2-14 years. Infants were still refused admission.

### The Hospital in the 20th Century

The hospital was growing. Admissions at the turn of the century were increasing:

1895—102; 1896—106; 1879—123; 1898—148; and 1899—160.

In this last year (1899) a new matron, Miss Grace Watson, was appointed. She remained until 1908. This same year, the hospital's name was changed to the Maurice Porter Children's Hospital, and the Board of Directors was increased to nine members with the addition of Mr. Dunlap Smith and Mrs. Murray Nelson, Jr.

The hospital continued to grow: in 1900 there were 209 admissions. The Board of Managers increased to 15 in number and nine Medical Board members were appointed. These doctors would care for the patients at the Maurice Porter Hospital. Many eminent physicians were on the Medical Board, including:

|                     |                       |
|---------------------|-----------------------|
| Dr. Frank Billings  | Dr. H. G. Anthony     |
| Dr. N. L. Harris    | Dr. W. S. Christopher |
| Dr. W. D. Storer    | Dr. G. L. Chapman     |
| Dr. W. W. Quinlan   | Dr. Normal Kerr       |
| Dr. Hugh T. Patrick | Dr. A. M. Hall        |
| Dr. J. P. Houston   | Dr. George F. Fiske   |

Prior to this Medical Board of distinguished physicians, all was not peaceful in regard to the medical staff. Mrs. Bowen tells the story:

I think it was about this time (1894 or 1895) that the managers, including myself, became very wrathful with the board of physicians. The children were not well taken care of. We all felt that we did not want to be connected with a hospital where we could not get physicians. The women managers held many meetings about it and went to see Dr. Oshsner, then Head of the Augustana Hospital.

He was an excellent surgeon and a very good man. We asked him if he would take charge of the Porter Hospital if we asked the old Medical Board to resign, and would he put in a new Medical Board and fill the hospital with children? He said that he would do it as soon as we wrote our letters to our Medical Board.

It was a very unusual thing to do, to turn out your Medical Board, but so many children had been positively lacking in medical care because we couldn't get any of the physicians connected with the hospital that I felt it necessary to present the plan, which was presented by me to the Board of Managers, who were in favor of it.

The letters were sent; the physicians resigned and Dr. Oshsner, with his Board, were about to move in. About that time I left the hospital in the hands of two women on the Board, and had to go East on business. To my sorrow, I received a telegram after I had been gone a day or two saying that the physicians who had been put out, had asked Dr. Oshsner and his physicians to stay out. They had put themselves in again and were going to work at the hospital.

I immediately resigned, together with many of the Board.

The hospital saw even more patients—282 in 1901, 260 in 1902, and 302 in 1903.

A complete reorganization then occurred. On March 9, 1903, a letter was sent to Mrs. Porter by the Board of Managers and Trustees of The Maurice Porter Children's Hospital stating that they felt the people of Chicago desired a well equipped, fire-proof children's hospital and asked her for a \$75,000 endowment to erect a new building. They also suggested the hospital's name be changed, for they felt that The Maurice Porter Children's Hospital indicated private rather than public interest.

Mrs. Porter replied by consenting to give the requested money to build one pavilion of a multi-building hospital, this pavilion to be known as The Maurice Porter Memorial.

In 1903, the name of the entire hospital complex was changed to The Children's Memorial Hospital, and in 1904 it was incorporated as a non-profit organization.

After 22 years of building and reorganization, The Children's Memorial Hospital was now an entity; and with the new name there came a great spurt of growth which lead to bold building programs culminating in the modern complex of today, the acquisition of a fine attending staff and international reputation. ▀

### Acknowledgements

I am indebted to Mr. Beatty and Miss G. Price for allowing me the use of the excellent historical facilities at The Northwestern University Medical School Library; to Mrs. B. Porte and Mr. J. Greer for allowing me the use of the historical information in the Department of Public Relations at Children's Memorial Hospital; and to L. B. Arey, Ph.D., Dr. R. B. Lawson, Dr. J. J. Boehm, W. K. Beatty, Dr. H. L. Moffet, and Dr. H. S. Traisman for reviewing and commenting critically on the manuscript.

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# The Importance of Vehicles in Topical Applications

BY SAMUEL M. BLUEFARB, M.D./CHICAGO

There has been an increasing awareness of vehicle effects on drug activity since the introduction of topical corticosteroids. It is no longer sufficient for a product to just look or smell good. It must also provide optimal therapeutic activity of the drug molecule in addition to physical, chemical and microbiological stability.<sup>1</sup> The drug vehicle factors likely to be of importance in the formulation of topical preparations have been enumerated by Poulsen<sup>2</sup> as follows:

1. Effects of vehicles on the integrity of the skin barrier or on skin permeability.
2. Particle size of poorly soluble suspended drugs.
3. Chemical nature of the drug.
4. Partition coefficient of the drug between the skin and vehicle.
5. Viscosity of the vehicle.
6. Drug concentration in the vehicle.

Demski et al<sup>3</sup> have suggested that the release of substances from topical bases is a function of their solubility in both the base and its surrounding media. Essentially, it is desirable for the drug to be soluble in its vehicle, but not so soluble as to preferentially remain in the vehicle. For topical corticosteroids Poulsen et al<sup>4</sup> have indicated that the vehicle should contain the minimum quantity of cosolvent (such as propylene glycol) required to completely dissolve the drug. Goldman et al<sup>5</sup> demonstrated an enhancement of percutaneous absorption of fluocinolone acetonide when it was dissolved in a mixed volatile: non-volatile solvent system. On the skin surface, the volatile constituent evaporated leaving a supersaturated solution of the corticosteroid from which penetration was maximal.

Ostrenga<sup>6</sup> and his colleagues suggested the following criteria for an efficacious topical gel formulation:

1. the concentration of the diffusible drug in the vehicle should be optimized by ensuring that all the drug is in solution.
2. The minimum amount of solvent should be used to dissolve the drug completely and yet maintain a favorable partition coefficient with the skin.
3. The vehicle components should affect the permeability of the stratum corneum in a favorable manner.

A new type of formulation for the presentation of topical corticosteroids have been developed for fluocinonide.<sup>7</sup> This vehicle consists of a continuous solubilizing phase distributed in a solid phase of fatty alcohol and high molecular weight polyethylene glycols. FAPG<sup>R</sup> is one such vehicle in which the solubilizing phase is propylene glycol which is distributed in a mixture of stearyl alcohol and a high molecular weight polyethylene glycol. *In vitro* studies showed good release rates from such formulations and *in vivo* vasoconstriction response for both open and occluded application correlated with the high percentage of drug solubilized in the vehicle. Physically the preparation combined the properties of a gel with the cream-like consistency and appearance of an emulsion system. Coldman et al<sup>8</sup> showed that fluocinolene was highly effective in FAPG formulation and surpassed the high responses obtained with betamethasone valerate cream and ointment in the blanching test.

Rosenberg<sup>9</sup> in a double blind paired comparison in 24 patients found fluocinonide 0.05% in FAPG base to be more effective clinically in the majority of cases than betamethasone valerate cream 0.1%. Barrett et al<sup>10</sup> also showed that when fluocinolone acetonide was suspended in the vehicle, reduction in particle size enhanced absorption. The absorption was further enhanced when fluocinolone acetonide was dissolved in propylene glycol before dispersion in the vehicle.<sup>11</sup>

Since first described by McKenzie and Stoughton,<sup>12</sup> *in vivo* vasoconstrictor tests have been used as a bioassay system for evaluating the biological effects and relative potencies of topically applied



SAMUEL M. BLUEFARB, Chicago, is Professor and Chairman, Department of Dermatology at Northwestern University Medical School.

TABLE 1

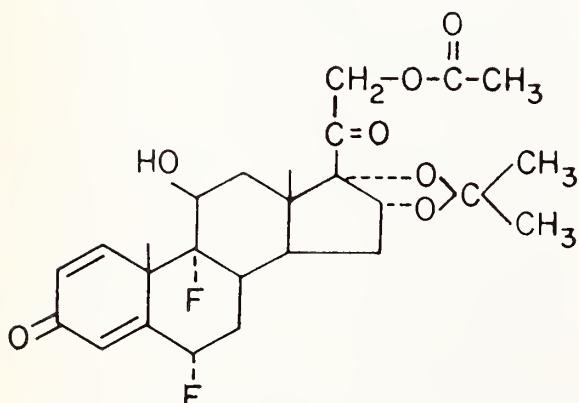
|                       | No. Patients | Excellent | Moderate Improvement | No or Slight Improvement |
|-----------------------|--------------|-----------|----------------------|--------------------------|
| Contact Dermatitis    | 6            | 5         |                      |                          |
| Psoriasis             | 4            | 2         | 2                    |                          |
| Seborrhea             | 6            | 4         | 1                    | 1                        |
| Eczema                | 5            | 1         | 3                    | 1                        |
| Stasis Eczema         | 1            |           | 1                    |                          |
| Varicose Eczema       | 1            |           | 1                    |                          |
| Nummular Eczema       | 4            | 4         |                      |                          |
| Infectious Eczematous |              |           |                      |                          |
| Dermatitis            | 1            |           | 1                    |                          |
| Atopic Dermatitis     | 1            | 1         |                      |                          |
| Lichen Planus         | 1            |           |                      | 1                        |
| Lichen Simp. Chron.   | 2            | 1         |                      | 1                        |
| Insect Bites          | 3            | 2         | 1                    |                          |
| Granuloma Annulare    | 1            | 1         |                      |                          |
| Drug Eruption         | 1            |           | 1                    |                          |
| Second Degree Burn    | 1            | 1         |                      |                          |
| Poly. Light Erupt.    | 2            | 2         |                      |                          |
| Intertrigo            | 1            |           |                      | 1                        |
| Alopecia Areata       | 1            |           |                      | 1                        |
| Pruritus Vulva/Ani    | 1            |           |                      | 1                        |
| Total:                | 43           | 24        | 11                   | 7                        |

(One incomplete case report form)

corticosteroids in man.

Recently, Place et al.<sup>13</sup> using their modification of the Stoughton-McKenzie assay, reported that fluoconinide showed five times the vasoconstrictor effect of fluocinolone acetonide, betamethasone valerate or triamcinolone acetonide (in alcoholic solution). The latter three compounds appeared to be approximately equipotent and showed 1000 times the activity of hydrocortisone in this study.

### Fluocinonide



Fluocinonide incorporated in the specially designed base (FAPG) was tested in 43 consecutive patients in which a steroid preparation was indicated. The results are given in Tables 1 & 2.

TABLE 2

|   |           |
|---|-----------|
| 43 Total Patients                                       |           |
| 23 males  |           |
| 20 females  |           |
| Age Range: 12 years to 87 years with an average of      |           |
| 47.1 years  |           |
| Disease Duration: 2 days to 20 years with an average of |           |
| 1.8 years   |           |
| Excellent responses                                     | (2+) = 24 |
| Moderate improvement                                    | (1+) = 11 |
| No improvement  | (0) = 7   |
|   | 42 total  |

One patient could not be included because of incomplete case report.

### Summary

The intrinsic activity of a topical drug is the most important factor in determining its therapeutic usefulness. However, there is little doubt that the release of a drug from a topical preparation can be materially affected by the vehicle in which it is applied. Correct formulation of a topical agent will ensure that it exerts its maximal activity on the skin while incorrect formulation may reduce its activity. For this reason, it is inadvisable for the proprietary products of the pharmaceutical industry to be diluted with other vehicles which, while producing a preparation which appears to be physically acceptable, may nevertheless have interfered seriously with the release and activity of the main ingredient. ▀

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(Continued on page 470)

# Angiomatous Lymphoid Hamartoma of the Mediastinum

By MOISES V. RIOS, M.D., IMMACULA CANTAVE, M.D. AND SIDNEY LEVITSKY, M.D./CHICAGO

*A patient with an asymptomatic angiomatous lymphoid hamartoma of the mediastinum of 25 years duration is presented. The pathogenesis of this lesion and its clinical manifestations are discussed. The major distinguishing characteristics of this mediastinal lesion that allows preoperative diagnosis are: 1) asymptomatic or minimal presenting symptoms; 2) slow growth; 3) no evidence of malignant change; 4) usually a solitary lesion; and 5) relative ease of extirpation. Surgical resection appears to offer an excellent prognosis as there are no reported cases of recurrence.*

Angiomatous lymphoid hamartoma is a rarely occurring lesion in the mediastinum and presents as a confusing pathologic entity. In the past it has been called primary hemangiolymproma of the hemal node<sup>1</sup>, a giant hemolymph node<sup>2</sup>, hyperplasia of the lymph node<sup>3</sup>, lymphnodal hamartoma<sup>4</sup>, tumor-like proliferation of lymphoid tissue<sup>5</sup>, giant intrathoracic lymph node<sup>6</sup>, follicular lympho-reticuloma<sup>7</sup> and angiofollicular mediastinal lymphnode hyperplasia<sup>8</sup>. The lesion has also been confused with benign thymoma<sup>9,10</sup>. The term angiomatous lymphoid hamartoma has been used because it indicates the benign nature of the lesion and its likely pathogenesis<sup>11</sup>. It is thought to represent either a lymphatic hamartoma or a hyperplastic reaction to a non-specific inflammatory process.

In 1954 Castleman<sup>3</sup> described a case of hyperplasia of mediastinal lymph node resembling teratoma; in 1956 he reported 13 more cases diagnosed previously as thymomas<sup>10</sup>. Since these

initial reports, more than 77 cases occurring throughout the body and 31 cases within the mediastinum have been presented in the literature, the latest by Haid and Shields<sup>12</sup>; an excellent review has been published by Tung and McCormack in 1966<sup>11</sup>. The purpose of this report is to add an additional case to the literature and to correlate the clinical and pathological features of this condition so as to allow consideration of the diagnosis in the preoperative period.

## Case Report

A 43-year-old Negro male was admitted to the West Side Veterans Administration Hospital on June 20, 1970, for rectal bleeding. A barium enema revealed a polyp in the descending colon. In addition, a large retrocardiac mass was observed on a screening roentgenogram of the chest. The patient had no complaints referable to the respiratory system but he recalled having been told that he had "something behind the heart" in 1945 when he was in the Army. Except for military service in Europe he had never traveled outside of the State of Illinois. There was no family history of respiratory disease or known exposure to tuberculosis. Physical examination revealed a healthy appearing slightly obese male. No abnormal physical signs were noted save for positive quaiac stool during the rectal examination.

Radiologic examination of the chest revealed a large oval shaped mass in the lower third of the posterior mediastinum (Figures 1A & B); a barium esophagram indicated external compression of the lower third of the esophagus. Laminography showed calcification within the mass (Figure 2) and a bronchogram revealed abnormal widening of the carina.

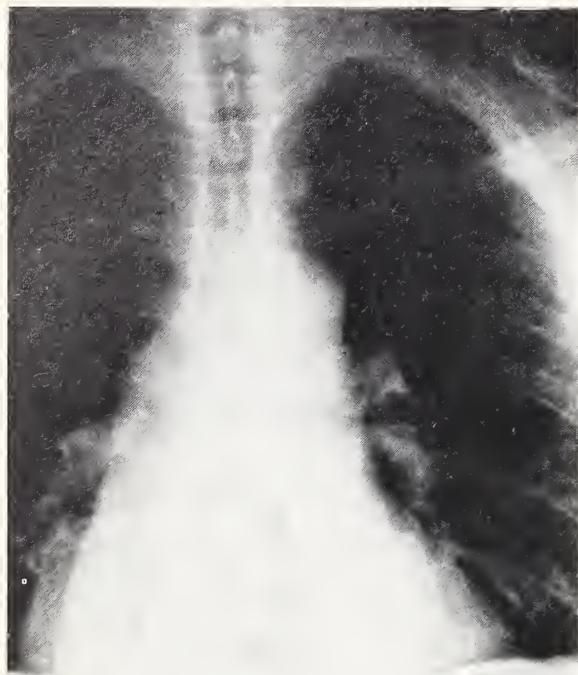


MOISES V. RIOS, M.D., at the time of writing he was on Instructor in Surgery of the Abraham Lincoln School of Medicine, University of Illinois. Dr. Rios is presently a cardiovascular surgeon in Panama.



SIDNEY LEVITSKY, M.D., is Chief, University Section, Division of Cardiovascular and Thoracic Surgery and Associate Professor of Surgery at Abraham Lincoln School of Medicine, University of Illinois. Dr. Levitsky, a graduate of Einstein College of Medicine, is an investigator for the American Heart Association.

At the time of writing, IMMACULA CANTAVE, M.D., was on instructor in Pathology at the Abraham Lincoln School of Medicine, University of Illinois.



**Figure 1.** Screening roentgenogram of the chest reveals a well circumscribed mass in the posterior mediastinum; A (anteroposterior view), B (lateral view).



**Figure 2.** Calcifications within the mass are visible in the anteroposterior laminogram.

Laboratory investigation revealed a normal blood count, negative serum fungal complement fixation studies and a positive intermediate strength PPD skin test. Sputum studies for tuberculosis and fungus were negative on smear and culture. Mechanical pulmonary function studies and a  $^{133}\text{Xe}$  lung scan were within normal limits. Bronchoscopic examination was unremarkable except for the widened carina and bronchial washings revealed normal cells on cytologic study.

A right posterolateral thoracotomy was performed through the bed of the sixth rib and a large rubbery mass was found in the posterior middle mediastinum. The lesion was well encapsulated and vascularized by three vessels arising from the adjacent intercostal arteries. There was no evidence of invasion or attachment to the surrounding tissues. The patient had an uneventful postoperative recovery period and three weeks later a benign polyp was removed from the descending colon. When seen two years postoperative, the patient was asymptomatic and exhibited no radiologic evidence of tumor recurrence.

***Pathology findings:*** The specimen consisted of an encapsulated, hemispherical mass with an uneven surface weighing 136 gm. and measuring 9X7X5 cm. The capsule was surrounded by richly vascularized adipose tissue. The cut sur-

face was light brown, gritty in appearance and traversed by wide, irregular fibrous bands, some of which appeared to extend from the capsule. An irregular calcified and ossified zone measuring about 3 cm. in greatest dimension was seen at one end (Figure 3). On microscopic examination the fibro-collagenous capsule and pericap-



**Figure 3.** Cut surface of the surgical specimen with an area of calcification in the left lower quadrant.  
sular fat tissue enclosed numerous thick-walled medium-sized muscular arteries, veins, and lymphatics. The following elements were recognized:

1. subcapsular sinusoids;
2. lymphatic nodules were scattered haphazardly and consisted of lymph follicles with and without germinal centers. The follicular structure was permeated by numerous intertwining capillaries with bulky endothelial lining, mimicking Hassal's corpuscles (Figure 4).
3. The interfollicular space was occupied by a rich angiomatic network closely associated with variegated cellular elements. The vessels were chiefly capillaries having prominent endothelial lining. The predominant cellular components were lymphocytes and reticulum cells.

#### Discussion

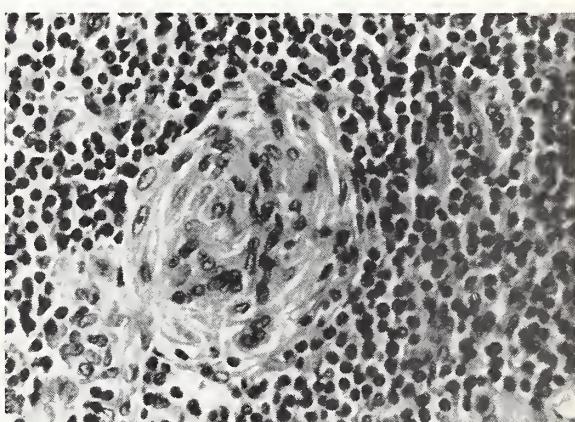
Angiomatous lymphoid hamartoma has remained a controversial lesion since its original description in 1921 by Symmer<sup>1</sup>. Including the present case there are at least 77 cases reported in the literature. One-third (24 cases) have occurred extra thoracically in such diverse locations as the arm, shoulder, chest wall muscles, retroperitoneum, pelvis, axilla and neck. Of the 53 cases that have occurred intrathoracically 41% (22 cases) have been located in the hilum or lung surface; the remainder (31 cases) have been equally scattered throughout the mediastinum. There appears to be no specific racial predilection as the lesion has been reported in whites, Blacks and orientals<sup>11</sup>. An age range of eight to 59 years has been noted with one half

of the cases occurring under the age of 30.

The vast majority of these lesions are asymptomatic, although there have been a few cases presenting with chronic dry cough, general lassitude and vague sensations of intrathoracic pressure. Lee and associates described an unusual case of an eight-year-old child with retarded growth, recurrent fevers and refractory anemia; all of these problems regressed after the tumor was removed<sup>13</sup>. Luthi and coworkers have recently described a similar case in a 16-year-old girl<sup>14</sup>.

Clinically, these lesions have been initially detected, as in our case, by screening roentgenographic examination. Stanford and associates have reported a patient, observed over an eight year period, whose lesion gradually increased in size despite a course of radiation and was finally surgically removed<sup>15</sup>. Preoperatively this lesion has been confused with neurofibroma, bronchogenic cyst, thymoma, adenoma, aortic aneurysm, congenital heart disease, and in our case because of the presence of calcification, teratoma.

Although the pathologic description of the lesion as a specific entity has been settled in recent years, there still exists controversy concerning the origin of the lesion. Evidence supporting the concept that the lesion represents a vascular hamartoma in a lymph node include: 1) the occurrence of the lesion predominately in young adults; 2) slow growth characteristics; 3) histologically and clinically benign; 4) distinctive systemic arterial blood supply; 5) abundant capsular blood vessels and proliferative stromal blood vessels. Of particular interest in our case was the presence of calcification within the mass, a feature reported only four times previously<sup>8, 16</sup>.



**Figure 4.** Microscopic section revealing follicular structure with obliterative endothelial proliferation mimicking Hassal's corpuscles.

Surgical extirpation remains the treatment of choice, because of the difficulty in differentiation from a malignant lesion and the possibility of encroachment on major bronchovascular structures. Because of size and proximity to major blood vessels in the mediastinum, the dissection may be tedious. However, there have been no cases reported with local invasion or inflammatory reaction that obscured the anatomy. Vessels leading to the tumor should be divided in continuity so as to prevent posterior mediastinal bleeding secondary to avulsion of the numerous small vessels supplying the mass.

The long term results of surgical resection appears to be excellent. There are no known cases of recurrence even with incomplete excision<sup>12</sup>. Abel and coworkers have reported a patient who is 19 years postoperative without evidence of recurrent disease<sup>17</sup>. The tumor is radioresistant as demonstrated by Stanford and others who noted continued growth of the lesion over an eight year period despite radiotherapy<sup>15</sup>.

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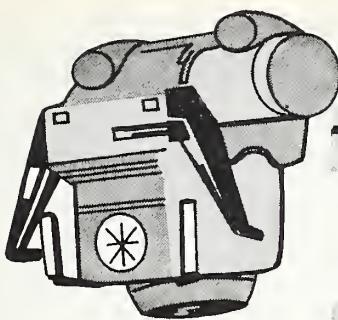
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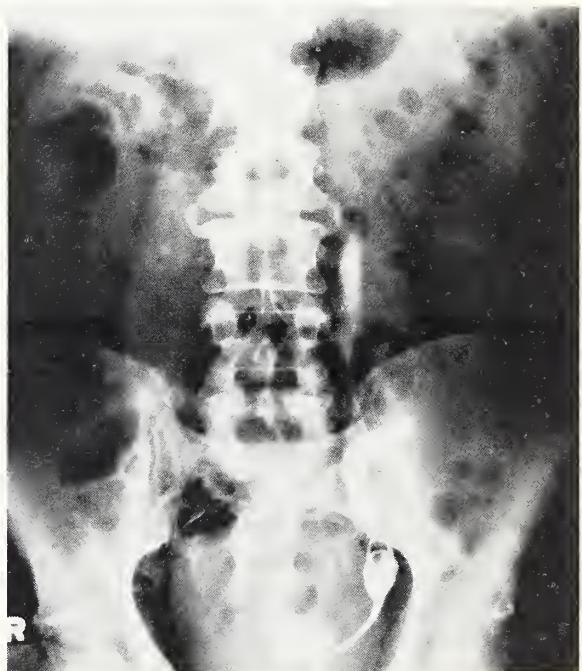
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# the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLoGY  
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The patient is a 58 year old male with pain in the left flank, hematuria and a palpable mass in the left renal area. IVP revealed a left hydronephrosis and hydroureter. A retrograde ureterogram was done.

What's your diagnosis?

1. A large blood clot
2. Stone in the ureter
3. Papillary carcinoma of the ureter
4. Extension of a carcinoma of the rectum to the distal ureter

(Answer on page 466)

# Experience With the Halo and Body Cast in the Ambulatory Treatment of Cervical Spine Fractures

BY DONALD W. LYDDON, JR., M.D./ROCKFORD

Although not all fractures of the cervical spine are associated with spinal cord injury, the potential for spinal cord injury always is being considered by the treating physician. For this reason, the approach to treatment is cautious. If there is any question as to the extent of bony injury, the tendency is to lean toward over immobilization, and rightly so. Until recent years, this has generally meant skull-tong traction on a turning frame for a minimum of six weeks or more, followed by immobilization in a brace or body cast for an additional six to ten weeks.

With rising hospital costs, although safe, this mode of treatment also is very expensive. It requires prolonged utilization of hospital bed space and personnel.

With the advent of the halo apparatus, an additional option is available to the treating physician without compromising the safety of the patient. The use of the halo apparatus was first reported by Perry and Nickel<sup>1</sup> as an apparatus for fixation of the cervical spine undergoing fusion because of muscle paralysis. Subsequent articles<sup>2-6</sup> have indicated the usefulness of this apparatus in the treatment of cervical spine fractures.

The apparatus consists of a steel ring fixed to the skull by four threaded pins passed through the ring. The ring is attached to a metal frame which is, in turn, attached to a body cast. Distraction between the skull and trunk can be obtained by means of this apparatus to provide fairly rigid immobilization of the cervical spine.

As pointed out by Nickel, Perry, and Associates,<sup>2</sup> the device provides:

1. Precise position control in three planes;
2. Progressive adjustable longitudinal traction;
3. Rigid stabilization;
4. Simple application;



DONALD W. LYDON, Jr., M.D., Rockford, is an orthopedic surgeon with a specialty in hand surgery. Dr. Lydon, a graduate of Northwestern University Medical School is a clinical Associate at the Rockford School of Medicine at the University of Illinois.

5. Freedom from complications during the prolonged use necessary for bone fusion;
6. Minimum patient discomfort.

Most significant, however, is the ability of the patient to ambulate and help care for himself while being treated and wearing the halo device and body cast. This prevents the complications associated with prolonged recumbent care including skeletal demineralization, renal calculi, disuse atrophy, thromboplebitis, and pneumonitis. With the ability to maintain the upright position at will and ambulate, the patient's general physiology is improved. The ability to ambulate and assume a portion of one's own care permits early hospital discharge and safe outpatient treatment of cervical spine fractures.

## Indications

We have used the halo brace and body cast in the treatment of cervical spine fractures when there is no neurologic deficit in the trunk or extremities. In one case it was used in a patient with a central cord injury or anterior spinal artery syndrome and upper extremity paralysis associated with a cervical spine fracture. The upper extremity paralysis eventually resolved. We have not used this device on individuals with spinal cord injury and paraplegia because of skin anesthesia and possible skin breakdown under the cast. In addition, since these patients are not able to ambulate, the halo and cast seems to provide little advantage.

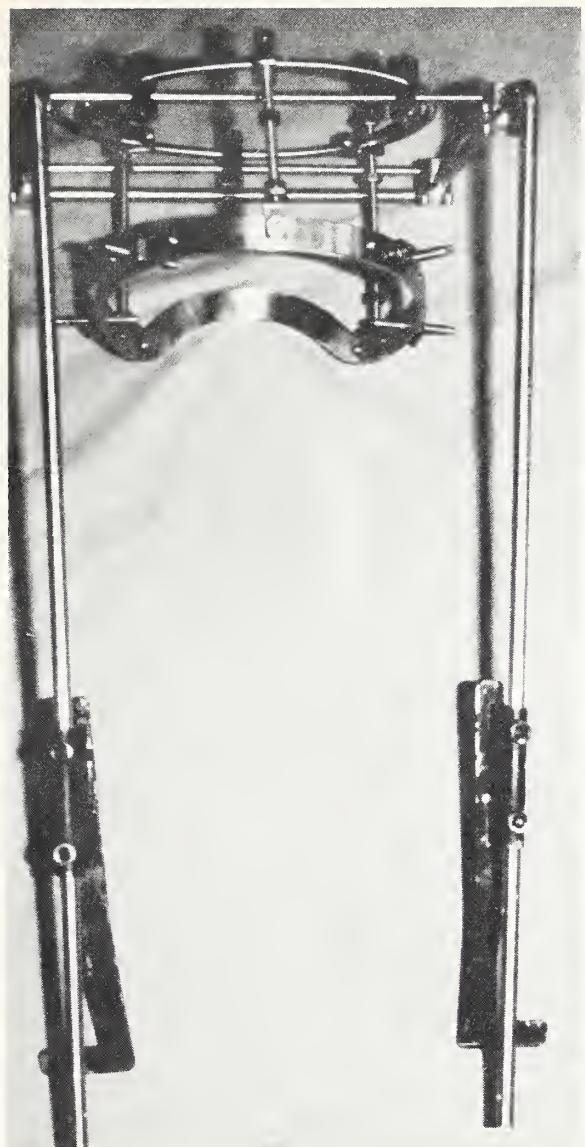


Figure 1. The halo and supporting frame.



Figure 3. Application of the halo, frame, and cast almost complete.



Figure 4. The patient is able to ambulate in the halo and body cast.

Figure 2. The patient positioned on the fracture table.

TABLE 1

| Age<br>(Years) | Fracture   | Neurologic<br>Findings  | Treatment  | Complications   | Time After<br>Injury of<br>Halo<br>Applie. | Time After<br>Injury of<br>Hospital<br>Discharge           | Follow-Up  |
|----------------|--|---|--|---|--|--|--|
| 14             | Sublux. C-2,<br>Comp. Fx.<br>C-3 & C-4.                      | Normal  | Crutchfield<br>Tongs.<br>Halo & Cast.  | None  | 10 days                                    | 16 days  | 7 months   |
| 29             | Jefferson<br>Fx. C-1.<br>Subluxation<br>C-2 on C-3.          | Normal  | Crutchfield<br>Tongs.<br>Halo & Cast.  | None  | 21 days                                    | 27 days<br>Home to Iowa<br>by Bus same<br>day.             | 6 months   |
| 51             | Pedicles<br>C-2.   | Normal  | Head halter<br>traction.<br>Halo & Cast.                                     | None  | 5 days                                     | 13 days<br>Home to New<br>Mexico by air-<br>line same day. | 12 months  |
| 16             | Sublux. C-3,<br>Comp. Fx.<br>C-4 & C-5.                      | Central cord or<br>artery syndrome<br>with upper extre-<br>mity paralysis; lower<br>extremity weakness. | Head halter<br>traction.<br>Halo & Cast.                                     | None  | 14 days                                    | 28 days  | 23 months<br>Normal<br>Neurologic<br>except inter-<br>osseous weakness |
| 18             | Body C-5,<br>Compression<br>C-6.                             | Normal  | Crutchfield<br>Tongs.<br>Halo & Cast.  | 2 pins<br>replaced<br>because of<br>drainage.   | 5 days                                     | 19 days  | 9 months   |
| 17             | Compression<br>C-5 with<br>posterior<br>displacement<br>C-5. | Congenital<br>Deaf-Mute,<br>otherwise<br>normal.  | 4-poster brace<br>(inadequate)<br>Halo & Cast.                               | I. Progressive<br>displacement in<br>4-post. brace.<br>Corrected with<br>Halo & Cast.<br><br>2. One pin re-<br>placed because<br>of drainage. | 12 days                                    | 18 days  | 14 months  |
| 23             | C-1 arch,<br>C-2 pedicles<br>and lamina.                     | Normal  | Crutchfield<br>Tongs.<br>Halo & Cast.  | None  | 5 days                                     | 9 days<br>Home to Iowa<br>by auto<br>same day.             | 6 months   |
| 28             | Pedicles<br>C-2 & C-6,<br>spinous pro-<br>cess C-7.          | Hypesthesia<br>one leg which<br>resolved.   | Crutchfield<br>Tongs.<br>Halo & Cast.  | Abdominal ileus<br>delayed applie.<br>of halo & east.   | 8 days                                     | 15 days  | 4 months   |
| 53             | Pedicles C-2,<br>60% disloca-<br>tion body of<br>C-2 on C-3. | Normal  | Crutchfield<br>Tongs; cervical<br>fusion openup<br>to C-4; Halo<br>and Cast. | Severe delirium<br>tremens lasting<br>2½ weeks.   | Fusion<br>14 days;<br>Halo<br>24 days.     | 42 days  | 11 months  |
| 65             | Pedicles C-2,<br>40% disloca-<br>tion body of<br>C-2 on C-3  | Normal  | Crutchfield<br>Tongs.<br>Halo & Cast.  | None  | 5 days                                     | 12 days  | 4 months   |
| 14             | Sublux. C-3<br>Comp. Fx.<br>C-4 & C-5.                       | Normal  | Crutchfield<br>Tongs.<br>Halo & Cast.  | Patient riding<br>his bicycle in<br>halo & east in<br>spite of warning<br>to contrary.  | 9 days                                     | 13 days  | Still in halo.<br>2 months   |

over conventional treatment.

### Method of Treatment

With three exceptions, all of our patients were initially immobilized on circle electric beds after application of Crutchfield tong traction immediately after hospital admission. The halo cervical brace and body cast was applied at a later convenient time using local anesthesia supplemented with narcotic analgesia. We have found the Crutchfield tongs to be most convenient because they do not protrude to the side beyond the width of the skull and thus do not interfere with the halo slipping over the skull. Traction can continue to be maintained by means of the tongs until after the halo is in place, the cast complete, and the final adjustments made on the frame of the halo.

The circumference of the head is measured to determine the size halo needed. A halo slightly larger than the head circumference is selected to allow space for clearance between the head and the entire halo.

After narcotic premedication, the patient is carefully transferred to an appropriately prepared Albee-Compere fracture table. The position of the head and neck is maintained using the head rest on the table and traction on the Crutchfield tongs, which is maintained by a ratchet windlass on the table. The head is prepared by shaving the anticipated sites of pin insertion, cleansing these with soap and water, and painting them with Betadine Solution. The shaving has been minimized or omitted in some female patients. A sterile halo is then passed over the rope to the Crutchfield tongs (which is temporarily held by hand) and passed over the skull. The rope to the tongs is reattached to the windlass and the halo temporarily held in place by halo positioning pins. These are passed through the threaded holes in the halo and have flat stabilizing plates snapped onto the blunt ends of these pins. The plates press against the scalp. The halo positioning pins are placed in holes adjacent to the holes which are used for the pointed skull fixation pins. The halo should be positioned low enough to allow a firm grip on the skull but yet not cause pressure on the ears or interfere with vision. Xylocaine is infiltrated into the skin and down to the skull at the sites of anticipated pin insertion. Sterile pointed pins are then screwed through the halo ring and into the skin and skull, two anteriorly and two posteriorly. The pins are tightened to 5-6 inch pounds torque

using a torque screw driver. The two diagonally opposite pins are tightened at the same time. No skin incision is necessary.

A plaster body jacket is then applied and the overhead frame for the halo attached to the cast and incorporated with plaster. The frame is attached to the halo and all adjustments made. If additional reduction of the fracture is required, it can be made at this time by using the various adjustments and traction which can be applied to the halo. Excellent control can be maintained while the reduction is completed. The patient is then transferred from the fracture table and the Crutchfield tongs removed. The patient can generally sit that night and begin ambulation the following day. Tension on the pins is tested and adjusted at three-week intervals.

The halo is worn for three months. After removal of the halo, a four-post or two-post cervical brace is prescribed for four to six weeks.

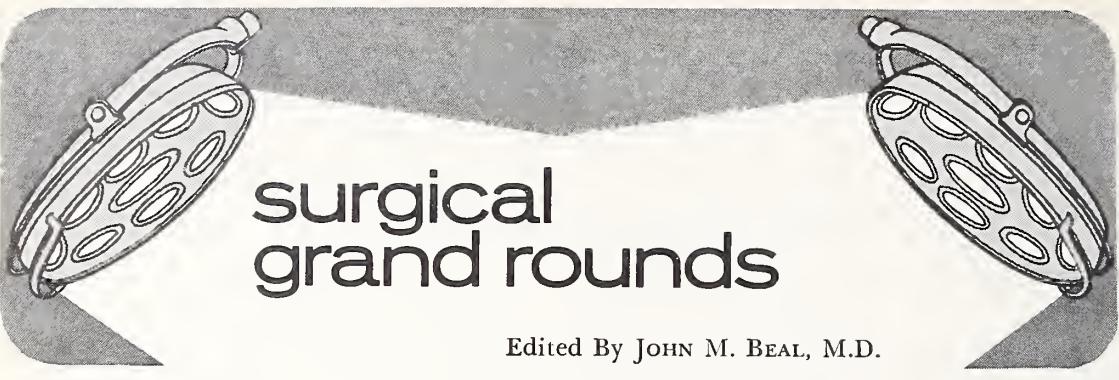
### Experience

We have used this method of treatment for 11 cervical spine fractures. These are summarized in Table 1. The level of fracture has varied from C-1 to C-7. In only one case was the halo used in addition to cervical spine fusion. In the other ten cases, no supplemental fusion was required and satisfactory healing has occurred without late instability. The ages ranged from 14 to 65 years of age. All patients have been without significant neurologic impairment except for one patient with a central cord or anterior spinal artery syndrome with upper extremity paralysis but no significant trunk sensory deficit. The upper extremity paresis was decreasing at the time of halo application and except for mild interosseous muscle weakness, normal motor power returned within several weeks of halo and cast application.

Several patients have been able to safely travel considerable distances to their homes on the day of hospital discharge wearing the halo and body cast. One man traveled 150 miles by bus; one woman traveled 900 miles by commercial airline; and another man traveled 200 miles by auto. The spine immobilization provided by the halo and cast allows safe transportation by conventional means.

### Complications

Only two patients had complications directly attributable to the halo. Both patients developed  
*(Continued on page 490)*



# surgical grand rounds

Edited By JOHN M. BEAL, M.D.

## Carcinoma of Lip

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium at the Passavant Pavilion. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of May 21, 1974.*

**Dr. Charles Hughes:** A 74-year-old retired school teacher had lesions on her lip and nose for a number of months. She complained of an ulcer on her lower lip which would not heal. Her past history reveals that she was a physical education teacher, spending much of her time out of doors.

When admitted to the hospital, the pertinent physical findings were limited to the skin of her face. There was a hard, scaling, ulcerating 1.5 cm. lesion on her lower lip and there was another crusting 0.5 cm. ulcer on the side of her nose. (Fig. 1) Blood count, urinalysis and SMA-14 were within normal limits. She was taken to the operating room and the day after admission a W-shaped wedge was removed from her lower lip which included the lesion. The lesion on the nose was excised with an elliptical incision. She recovered without complications and had her sutures removed as an outpatient.

**Dr. Hector Battifora:** Sections taken from the edge of the ulcer of the lip show a normal epithelium. Underneath there are irregularly shaped islands of uniform cells resembling those of the basal portion of the skin. They have a tendency to palisade at the periphery of the islands as basal cells normally do. (Fig. 2) Occasionally there is a very marked keratinization in the center of these nests and a resemblance to hair follicles results. In summary, this is a fairly typical basal cell carcinoma. The margins of excision appear free of tumor.

**Dr. Hughes:** Carcinoma of the lip is one of the common head and neck cancers. The male-female ratio for the upper lip is 4 to 1, for the lower lip 9 to 1. Micro-lymphatic spread is seen approximately 40% of the time in the upper lip on the initial specimen and ultimately 8 to 14% in the lower lip. Carcinoma of the lower lip is more frequent than carcinoma of the upper lip. This frequency difference has been widely studied measuring actinic radiation. The lower lip receives 7 to 8 times as much actinic radiation as the upper lip. While this is felt to be the primary



Figure 1. The lesion on the lower lip was hard and ulcerating. The smaller lesion is visible on the nose.

cause, chronic trauma from jagged teeth, smoking, or chewing tobacco are felt to be etiologic adjuncts. The patient presented has had cracking of her lips and chronic chelosis lasting several months while at the seashore. The signs and symptoms are wounds that do not heal or a persistent mass. They often present together but not necessarily. Precursor lesions may be leukoplakia, a chronic chelosis, or any of the chronic irritating inflammations of the skin around the lip.

The diagnosis of a carcinoma of the lip is made only by biopsy. Carcinoma of the lip has a highly variable appearance and persistent lesions must be biopsied. Histologically, 98% of the true lip lesions are squamous cell while only 2% are basal cell. Surgical cure rates are not significantly better than radiation, but we do have reasons why we prefer surgery on a patient with carcinoma of the lip. Adequacy of the margins can be evaluated with frozen section. The permanent section, of course, confirms the diagnosis and also confirms that our margins are adequate. We feel that we can obtain a better long-term cosmetic result with surgical procedure and the somewhat nebulous risk of future radiation disease is eliminated by choosing surgery as a primary therapy for carcinoma of the lip. We see more carcinoma of the lip in this era of sun-worshipping in younger people. What will happen to the 39 or 40 year old patient that you radiate for carcinoma of the lip when he's 65?

The W-wedge is better than the traditional V-shaped wedge both for cosmetic results and to remove more of the lymphatic drainage. A neck dissection is indicated for carcinoma of the lip only when clinically positive nodes are presented.

The five year survival for stage 1 and stage 2, that is stage 1 being superficial, stage 2 being into the muscle but no nodes, is 85%. Stage 3 which is local nodes or stage 4 which is distant metastasis has a 5 year survival of 59% in conjunction with radiation and a radical neck dissection.

**Dr. John Beal:** This is a problem treated by both surgeons and radiotherapists. Dr. Moss is here. Can you tell us your attitude concerning carcinoma of the lip?

**Dr. William Moss:** The lesion which this lady had was small and adequately treated. Radiotherapy is particularly useful, however, in treatment of carcinoma of the lower lip in those circumstances where significant loss of muscle, of nerves and a poor cosmetic appearance would result from a wide excision. Radiation does have the capability of preserving these tissues. There-

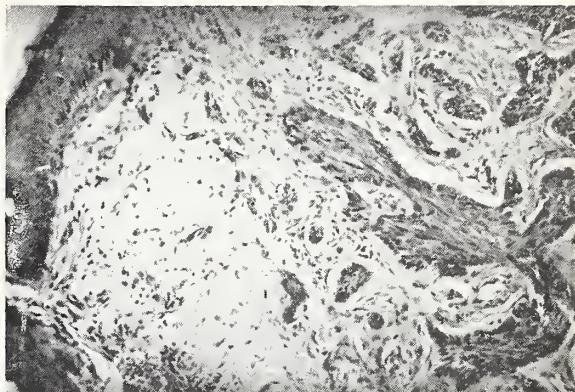


Figure 2. Photomicrograph of biopsy of lip which shows essentially normal surface epithelium. Irregular islands of basal cell carcinoma are present in the dermis (note palisading of peripheral cells).

fore, the choice of therapy is strongly influenced by size. I would regard any lesion which requires less than a two centimeter loss of lower lip quite adequately treated by surgery without much resultant deformity. Many older patients have a rather loose lower lip anyway and some of them are better looking after surgical excision. When the lesion is more than two centimeters in diameter, radiation is a valid competitor and provides excellent cosmetic results. However, if a massive destructive lesion is present, repair will be required regardless of the method of treatment. Such lesions are best treated by surgery from the very start to avoid repair in heavily irradiated tissue. I formerly worked in the Missouri State Cancer Hospital and we would see about 50 cancers of the lip treated by radiotherapy each year. Many had advanced carcinomas of the lower lip, extending almost from commissurae to commissurae, and I'm sure from a surgical standpoint you can envision the type of excision that would be necessary. Excellent results were obtained with radiotherapy when there was not massive destruction of the tissues of the lower lip.

When radiotherapy is used, a lead shield can be made, individually tailored to suite the particular circumstance, to protect the surrounding tissues. The center part of the lip is pushed back between the lip and the gum to shield the transmitted radiation from the teeth and the gum. The area treated by irradiation is essentially the same volume that the surgeon would have to remove. However, muscles, nerves and function are maintained and a deformity around the lips or a function of the mouth is unnecessary. Surgery is preferred for the control of lymph node metastasis. However, if the pa-

(Continued on page 478)

## Pediatric Perplexities

Ruth Andrea Seeler, M.D., Editor

# Hyponatremia and Central Nervous System Disease

BY NATESAN JANAKIRAMAN, M.D. AND MEHERNOOR WATCHA, M.D./CHICAGO

*"Pediatric Perplexities" is a series of encounterable, but slightly uncommon, pediatric disorders which require prompt diagnosis and specific management for a good outcome. The editor welcomes suggestions for types of cases that the readers would like to have presented and discussed.*

A 23-month-old Black female was transferred to the Division of Pediatrics of the Cook County Hospital because of lethargy, irritability, temperature of 101°F and persistent hyponatremia, in spite of hypertonic saline infusion. About one month earlier, the child was noted to have a dry cough accompanied by fever varying from 100° to 101°. This was thought to be a "teething problem." Two weeks prior to admission, the patient began to have repeated episodes of vomiting and the temperature elevations were as high as 104°F. The child was treated with cough syrups without effect. On admission to the other institution, she was markedly lethargic, with signs of meningeal irritation.

Lumber puncture showed the cerebrospinal fluid (CSF) to contain 159 cells of which 130 were lymphocytes and 29 were polymorphonuclear leukocytes, protein 70mg% and glucose 70mg%. No bacteria was seen on gram stain.

Hyponatremia, 119 mEq/L, was present. Infusion of 300 cc's of 0.9% sodium chloride produced no change in the serum sodium level. The patient was transferred to Cook County Hospital for further management upon finding a positive intermediate strength PPD.

On transfer, the child was lethargic with a temperature of 101°F with normal vital signs. The right pupil measured 6mm and was 2mm larger than the left, with both responding sluggishly to light. The eye grounds appeared normal. There was marked nuchal rigidity, positive Kernig's signs and Babinski signs, symmetrical and slightly accentuated deep tendon reflexes.

The PPD applied at the other institution showed 15mm of induration. X-ray examination of the chest (Fig. 1) revealed diffuse bilateral parenchymal infiltrates and skull X-ray (Fig. 2) showed widening of the suture lines.

A repeat lumbar puncture showed an opening pressure of >400mm of water, the CSF con-



Figure 1

tained 61 cells, of which 35 were lymphocytes and 26 polymorphonuclear leukocytes. The protein was 113mg%, glucose 47mg% with a simultaneous blood glucose of 110mg%. The electrolytes (Table I) showed hyponatremia, hypochloremia, low serum osmolality with an urine osmolarity greater than that of the serum.

## Management Quiz

Prompt fluid management for this patient would include (select as many as appropriate)

1. Normal volume of intravenous fluids
2. Restrict volume of intravenous fluids to less than normal maintenance for age
3. More than the normal maintenance for age
4. A push of 3% sodium chloride followed by maintenance fluids
5. 0.9% sodium chloride 20cc/kg

NATESAN JANAKIRAMAN, M.D., is attending physician in the Department of Pediatrics, Cook County Hospital and Hektaen Institute for Medical Research, Chicago. MEHERNOOR WATCHA, M.D., is a Resident in the Department of Pediatrics, Cook County Hospital.



**Figure 2**

## Discussion

The patient presents the classical example of the syndrome of inappropriate antidiuretic hormone secretion (SIADH) secondary to increased intracranial pressure. In this case, due to tuberculosis meningitis in a child with miliary tuberculosis.

SIADH is essentially water intoxication with normal water intake due to inappropriate ADH production with consequent water retention. The laboratory hallmarks are a low serum sodium, low serum osmolality, with disproportionately elevated urine osmolality. In our patient, the serum osmolality of 248 was below the normal range, while the urinary osmolality in the face of this hyponatremia was greater than the serum osmolality.

Therapy for SIADH is that of restriction of water. The infusion of hypertonic saline solutions no longer is considered appropriate, except to control convulsions. At the other institution, the child received 0.9% sodium chloride which had no effect on the serum sodium or the serum osmolality. Fluid restriction to approximately  $\frac{2}{3}$  maintenance fluids resulted in a prompt return of the serum sodium and the serum osmolality to normal.

Generally, 1200-1500cc fluids per meter square is required for maintenance of normal fluid balance. The patient under discussion weighed 10kg on admission and required 600-750ml for maintenance of a solution like 5% dextrose with

**TABLE I**

| Date & Time                           | 7/11/74<br>10.00 | 7/11/74<br>22.00 | 7/12/74<br>10.00 | 7/12/74<br>14.00 | 7/12/74<br>21.00 | 7/13/74<br>10.00     | 7/14/74 |
|---------------------------------------|------------------|------------------|------------------|------------------|------------------|----------------------|---------|
| Na (mEq/L)                            | 117              | 125              | 131              | 133              | 137              | 135                  | 140     |
| K (mEq/L)                             | 3.9              | 4.1              | 4.4              | 5.1              | 5.4              | 4.0                  | 3.2     |
| Cl (mEq/L)                            | 85               | 88               | 98               | 101              | 102              | 100                  | 96      |
| CO <sub>2</sub> content (mEq/L)       | 20               | 22               | 20               |                  |                  | 24.6                 | 27      |
| BUN (mg%)                             | 4                |                  | 6                |                  |                  | 8                    |         |
| Serum Osmolality (280-295) milliOsm/L | 248              |                  | 270              |                  |                  | 280                  |         |
| Urine Osmolality                      | 258              |                  | 291              |                  |                  | 720                  |         |
| I.V. fluids                           |                  |                  |                  |                  |                  | Alert on oral fluids |         |
| 600ml for 0.5m <sup>2</sup>           | 450ml            |                  | 450ml            |                  |                  |                      |         |

electrolytes 25 mEq/L of sodium, 20 mEq/L of potassium, 3 mEq/L of magnesium, 24 mEq/L of chloride, 23 mEq/L of lactate and 3 mEq/L of phosphate. She received 450cc/24 hours which is approximately  $\frac{1}{3}$  maintenance and promptly corrected the electrolyte disturbance. (Table 1).

The child was treated with triple drug regimen (streptomycin, INH and Rifampin in appropriate doses) and a six-week course of steroids. She was discharged after five weeks and is now on INH and PAS and has no recognizable neurological sequelae.

The clinical setting in which increased ADH secretions and dilutional hyponatremia occurs include:

A. Ectopic ADH Syndrome due to tumors of lung, pancreas, thymus, duodenum and brain.

B. Persistent pituitary ADH secretion—secondary to:

1. CNS—meningitis, head injury, brain abscess, encephalitis, subarachnoid hemorrhage, Guillain-Barre Syndrome, tumors.
2. Pulmonary—tuberculosis, pneumonia, aspergillosis.
3. Endocrine-myxedema and glucocorticoid deficiency.
4. Postoperative states.
5. Drugs—diuretics chlorpropamide, morphine and its derivatives, vincristine.
6. Idiopathic.

**Laboratory Data:** Decreased—serum sodium, osmolality, BUN.

Relatively increased—Urinary sodium and osmolality.

Normal or increased—blood and extracellular fluid volume.

#### **Management of SIADH in All Patients Regardless of Etiology:**

1. Restriction of water always raises serum solute concentration in SIADH, except in untreated Addison's disease and renal disease. These measures are adequate in almost all cases.

2. When convulsions due to hyponatremia are present, hypertonic saline, 3% NaCl, infused slowly will produce immediate cessation of seizure activity. The amount of hypertonic saline to be infused is calculated by using the formula: (Concentration desired—present Na mEq/L) x

wt. kg x 0.7. The 0.7 is the distribution factor for sodium.

However, if the water intake is not subsequently restricted, the sodium is rapidly excreted in urine and serum sodium concentration often returns to the initial low value within a single day. ▶

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## **View Box**

(Continued from page 457)

**DIAGNOSIS:** Papillary carcinoma of the distal ureter.

This tumor occurs primarily in the 4th and 5th decades of life with 75% appearing in the lower third of the ureter. The diagnostic triad consists of pain, hematuria and a palpable mass in the renal area. The palpable mass is usually the result of a hydronephrotic kidney. The major radiologic findings of primary carcinoma of the ureter are:

1. Intraluminal filling defect with local expansion of the ureter.
2. Cupping of the contrast around the margin of the lesion.
3. Fixation of the lesion to the ureteral wall.
4. Coiling of the retrograde catheter below the lesion.
5. Varying degrees of proximal obstruction.

Coiling of the ureteral catheter results from the growing intraluminal mass producing dilatation of the ureter below the tumor, allowing the catheter to coil upon itself when striking the obstructing lesion. With obstructing calculi the ureter immediately below the lesion is collapsed, and the lumen usually will not be of sufficient size to allow coiling of the catheter. ▶

# Neurology—Epilepsy and Learning Disorders\*

BY ALEX J. ARIEFF, M.D./CHICAGO

For the past few years I have been a neurologic consultant for the Chicago Board of Education. For the most part, these case histories consist of problem children with epileptic disorders with or without behavior disorders; hyperkinetic children with or without learning disorders; children with obvious physical brain disturbances, with or without learning troubles.

More recently parents and educators are stressing learning disorders, no matter what the cause or associated conditions. It may be of interest to discuss some of the neurologic conditions found with defects in learning. Basically everybody may have a learning disability, but some are better equipped to learn than others. Most of these are on a developmental basis. For a period of time doctors were intent on finding small neurological signs (M.B.D., minimal brain dysfunction) explaining some of the learning disabilities. It is well known that a child with severe neurological signs, i.e. cerebral palsy, may have no trouble learning. Likewise, he may have no obvious or minimal (M.B.D.) objective neurological signs but yet have definite specific difficulty in learning when tested properly. This is being recognized more of late.

Briefly, learning may be influenced by:

1. Early infections causing encephalitis or encephalopathy, i.e. hemiplegia, cerebral palsy, choreoathetoses; with or without obvious objective signs.

2. Vascular anomalies or diseases of the brain which may cause physical disturbances and perhaps interfere with learning in various degrees.

3. Tumors of the brain which have been operated upon or in the process of being diagnosed in which physical disabilities, seizures or behavior disturbances have been produced and there is a problem in school.

4. Injuries of the brain with encephalopathy producing either seizures, behavior, or physical disturbances which may affect learning in school.

5. Possible retarded mental development in a child who appears to be normal, but his ability to learn to an average degree is hampered. The child needs special help.

6. Delayed development: mental or motor, or involving perceptual and other learning functions of the brain.

7. Paroxysmal disorders of the brain, i.e. convulsive disorders, epilepsies.

8. Degenerative or metabolic disorders affecting brain functions, i.e. thyroid disease, diabetes, congenital, etc.

On testing, these children may be found to have difficulties in perception of visual, motor, or auditory stimuli. This may produce troubles in reading, arithmetic, and speech communication. We would like to focus on some of the more common conditions.

## Learning Disorders (Classical)

There are many in the medical or other allied professions including educators who still do not believe there is such an entity as learning disorders. Larry B. Silver stated that there may be as many as 7 to 15% of any school population having trouble with learning because someone has ignored the "Neurological Learning Disability Syndrome." In other words, we must look for it when a child has troubles. M. R. Gomez has written on "Specific Learning Disorders in Childhood." The patho-physiology of these disorders is not clear, but many assume "that they are due to late acquisition or arrested development of cerebral functions." Most of our knowledge of the cerebral mechanisms involved in learning derives from clinical observations on the effects of acquired cerebral lesions. These neurologic-psychologic observations have permitted us to formulate concepts on higher functions of the nervous system.

Most neurologists are familiar with acquired aphasia, alexia, agraphia and the like from insults to certain areas of the cerebral cortex or underlying white matter. These symptoms are clinically manifested as dysfunctions of communication and perception. Knowledge is still



ALEX J. ARIEFF, M.D., is Associate Professor of Neurology and Psychiatry at Northwestern University Medical School and Neurologic Consultant for the Chicago Board of Education.

\*Read at the First Annual City Wide School Health Conference Chicago, 1972.

scarce on these functions. If one searches the earlier literature of the 1930's, one will see many pathological presentations in which learning has specifically become defective because of an insult to the brain; i.e. Parietal lobe defects in which a person may not be able to add, but may be able to subtract; may be able to divide, but not able to multiply, etc.

It seems understandable that if these parts of the brain do not develop as one expects, then the person may show, as we have mentioned, some type of dyslexia, analogous to aphasia, agnosia, apraxia, or dyscalculia, manifesting itself as difficulty in reading or writing or doing arithmetic, etc. On routine psychological tests these might not be discovered.

Specific Disorders of Learning are:

#### *1. Developmental dyslexia*

Developmental dyslexia may occur in 10-15% of school children. In 1968 the World Federation on Neurology defined reading disability or developmental dyslexia as a "disorder manifested by difficulty in learning to read despite conventional instruction, adequate intelligence and social-cultural opportunity." Orton, 40 years ago, started work as the Director of Language Research Project at the Neurological Institute. This disability was called generically, "congenital word blindness." Alexia is the name properly applied to the total inability to read.

Diagnostically it is simple if these defects are associated with other neurological findings, i.e. of parietal lobe defect with confusion of laterality, finger agnosia and dyscalculia. For the neurophysiological basis for dyslexia, one must understand that reading is the perception of written symbols and decoding from their sequential arrangement the spoken word equivalence. So that the disabled or poor reader with developmental dyslexia may:

- a. Fail to recognize letters.
- b. Forget the orientation or directionality of a letter as when he confused "d" with "b", or an entire word, "on" for "no."
- c. Fail to perceive the length of a word or number of letters forming it leading him to misinterpretation by omission of part of the word.
- d. Transposes sequential arrangements of letters in a word.

Standard tests to help diagnose developmental dyslexia include Gray's Oral Reading Paragraph, Wide Range Achievement Test and the Wechsler Intelligence Scale for children.

#### *2. Developmental spelling disability*

Although some consider spelling disability as a part of development dyslexia, Critchley believes that an entity which could be labeled "specific spelling defect" probably exists as a sequel of a previous state of dyslexia.

#### *3. Developmental writing disability*

Writing disability may be either due to manual disorder or to a disorder of expression using written words. The manual disorders are a type of dysgraphia which may be a form of dyspraxia, sometimes similar to drawing disability. The second disorder, similar to an acquired form of agraphia, sometimes accompanies alexia in the acquired lesions of the left angular gyrus.

#### *4. Developmental dyscalculia*

Dyscalculia may be a part of reading disability or dyslexia. If the child is not able to read or write numbers, his learning for arithmetic may be faulty. The child may not be able to write digits in the proper sequence. Dyscalculia resembles acalculia which is an acquired disorder secondary to a lesion in the parietal cortex, usually the right nondominant lobe.

#### *5. Drawing disability*

Drawing disability depends on manual praxis. On copying, one must be able to perceive the model and then coordinate movements of the hand to reproduce the model. This is a complex process called visual-motor coordination. Difficulties in this area are usually picked up by the Bender Visual-Motor Gestalt Test, which shows as fragmentations of figures, incorrect angulations and rotations. Often such disability may be part of a neurological syndrome including other disturbances such as dyslexia, hyperkinesia, etc. Although there is a pure disorder of praxis, visual perception or both may affect the ability to copy or reproduce from memory geometrical designs. The Goodenough-Harris Draw a Man, Draw a Woman Test not only measures the Children's intelligence, but also indicates the individual's praxis for drawing or motor co-ordination as well as his concept of body as a "visual image."

#### *6. Developmental dyspraxia*

Developmental dyspraxia or clumsiness means difficulty in performing involuntary movements in the absence of weakness, spasticity, ataxia or involuntary movements. It may be general, and affect all movements or partial movements. It may be localized to parts of the body. The parents usually recognize this, and these children are the brunt of their peers. It may be simple to recognize in kindergarten children who can not put on a coat, tie shoelaces or hold a pencil.

## **Hyperkinesia**

In addition to these specific learning disabilities which are mainly developmental I have seen many children with hyperkinesia, who because of their increased movements or inability to remain in one spot, or due to a short attention span, are unable to learn, although intellectually they test above normal. They may or may not show any obvious neurological signs. Many of them show minimal neurological signs, which I feel may have nothing to do with their syndrome, but is a sign of immature nervous systems. At times these may be part of a convulsive state with or without EEG abnormalities. Some of these respond to analeptic drugs such as Ritalin® or amphetamines better than to barbituates or Dilantin®. Control studies with other drugs are needed. The trial is usually empirical and parent and teacher follow-ups are very important in relaying what is happening to the child in school or at home. When they respond they do so rapidly, i.e. days, rarely weeks. There should be a rapid appraisal to show the need for long term trial.

## **Epilepsy and Learning**

Another large group that I see are children referred because of epilepsy. At times, the consultation is just to check on treatment and the child, in the majority of cases, has no problem whatsoever. One must remember that epilepsy is still a symptom, not a disease in which there is a paroxysmal disorder usually with alterations in consciousness such as black outs or cloudy states, with or without a classical convulsion. These are usually classified simply as: 1. Grand mal; 2. petit mal; and 3. equivalent or psychomotor states in which there may be a convulsion or just a black out or peculiar behavior, such as temper tantrums. There may be more problems with associated conditions than with seizure states.

In all seizure states the problem is diagnosis and one must attempt to determine definite cause such as brain injury, brain tumor, inflammation of the brain, metabolic disturbances, circulatory diseases and other medical causes.

Clinical tests for epilepsies include a clinical neurological evaluation with an EEG and whatever other neurological and medical tests are indicated, such as a spinal fluid examination, pneumoencephalogram, brain scans and the like, to properly treat the child. If the patient does not show any physical abnormalities that require surgical therapy, then medical treatment in an

attempt to stop the seizures is the method of choice.

## **Conditions With Seizures Affecting Learning**

### *A. Uncontrolled seizures*

When seizures are not controlled, this may interfere with learning. This requires intensive medical care over a period of time with family, patient, teacher and doctor cooperation.

### *B. Frequent petit mal or status*

Many times a child has many petit mal seizures (status?) not recognized, and the child is accused of not paying attention or behaving badly. Actually he may be having multiple seizures of a status nature so that the child appears to be and is not in good contact. Petit mal status usually requires EEG corroboration. Intensive drug treatment usually helps these children.

### *C. Psychomotor seizures (unrecognized-bizarre)*

The post-seizure state may interfere with learning, as occurs in many psychomotor or equivalent seizures. At times they react with impulsivity, increased agitation or a hyperkinetic state as part of the seizure or post seizure state. The children may act automatically and look like they are in a clouded state, or have a behavior reaction to their clouded state so that they are accused of bad behavior.

### *D. Drug Reaction*

Where there is trouble in stopping seizures because of the necessity of using more than one drug, the child may have a drug reaction or intoxication which again may cause difficulty in learning. Measuring blood drug levels is a great help. Gas liquid chromatography is a recent help.

### *E. Inadequate treatment*

I see more patients who are on inadequate medication because of the family being fearful or due to anxiety or lack of knowledge of appropriate drugs. The patient continues to have seizures although he supposedly is on adequate medication. Families must be reassured that medications do not cause deterioration. Neurological consultation many times will be helpful. Here again blood drug levels are helpful.

In this drug oriented age, anti-convulsant medication for epilepsy is rarely a cause of difficulty. The bigger problem is making the patient and family aware that the patient must be on medication and supervision.

We have a recent aid in gas-chromatography which can measure the amount of a drug or drugs that a patient has in his blood when he is treated for his convulsive state. This helps

us to be sure that the child is: 1. taking his medication; 2. the level is therapeutic; and 3. an indication as to whether or not he is over or under medicated.

#### F. Behavioral reactions

Behavioral reactions may be a separate or associated state, but may resemble a seizure state. Neurological evaluation including an EEG and psychological tests are very important. Temper tantrums or outbursts may be part of a psychomotor seizure, but also may be part of an emotional disorder. These require study in order to be properly diagnosed as an additional disorder or a reaction to the seizure.

It is a misconception that because a child has epilepsy he also has a personality disorder or other defects. He may develop a personality reaction because of his isolation, peer reaction and social reactions. This is gradually improving in our society. All symptoms of the patient must be studied for proper treatment.

#### G. Educational aids

One of the big problems that I see in school children is that the family of the child does not document the problem, whether it is with medication, the frequency of seizures, or the problems that the child is having at home or in school. Documentation and observation are important for the parent, teacher and child, so that the physician and teacher-nurse know what the problems are for proper therapy. Many children are kept home because of anxiety on the part of the parents. They are sometimes excluded from class because of continued seizures which can be controlled if proper treatment is given. There is considerable literature for teachers, teacher-nurses, or parents available through the Epilepsy Foundation which can help in education. Many requests are made for special classes for children which is not only unnecessary, but is rarely of any help. The child should be treated as normally as possible. The parents and teachers must understand this.

#### Summary

The treating physician and educator must be aware that there is such a thing as learning disorders. There are many causes for learning difficulties. These are usually on a developmental, neurological basis even though there may not be any obvious objective neurological signs. Neurological consultation does not mean only a tapping of reflexes or sticking with a pin. Simple perceptual and motor reflex measurement, or visual acuity testing, is inappropriate to identify

learning difficulty causes. It requires special testing of coordination, drawing ability, perceptual testing; and sometimes this is best done by a trained psychologist. Special testing of the child, not a simple IQ test or EEG, will bring out these problems. If this is not possible, a qualified psychologist or the Chicago Board of Education Child Study Department (Psychology), does an excellent job in thorough child studies which bring out the defects in learning so that proper recommendations can be made. Usually the doctor is aware of what is necessary and what consultation should be requested. Convulsive (epileptic) disorders and associated conditions may cause difficulty in learning. Cooperation of patient, family and educators are necessary for proper solution of these complex conditions. Great progress is being made, although slowly. ▶

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#### President's Page

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## The Importance of Vehicles in Topical Application

(Continued from page 452)

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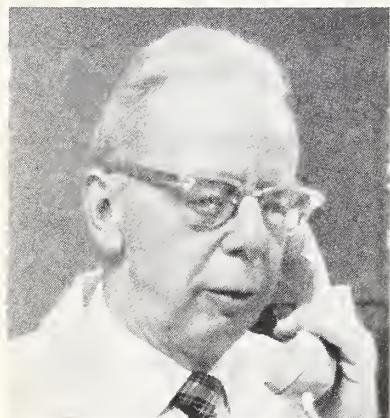
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## *President's Page*

# Close Ranks!

As I write this message, the "call" has been issued for yet another special session of the House of Delegates to further consider and reassess the position of organized medicine in Illinois in the matter of professional standards review.

By the time this message reaches you, the die will have been cast and the issue decided. Hopefully, the debate will have been reasonable in content, amicable in tone and enlightened by the expressions elicited in the opinion poll of the membership.

Whatever the policy established by the House of Delegates, let us close ranks, accept the will of the majority and, united, work for its effective implementation.

Let Thanksgiving, 1974, be an occasion for celebrating the restoration of harmony in our ranks and unity of action in our efforts to accomplish the purposes of the Illinois State Medical Society and its components.

A cursive signature of Fredric D. Lake, M.D.

Fredric D. Lake, M.D.,  
President

# *Doctor's News*

**MALPRACTICE SUIT FILINGS**—Upon review of filings in the Cook County Court Law Division, the numbers of suits being filed for all malpractice claims is increasing dramatically. The number of filings in 1974, through October, has increased by over 65% compared to the same 1973 period. A record-high Illinois award of \$2,500,000 in a medical malpractice claim, October 31, may set a precedent for future large awards. Recent information indicates that some carriers are increasing premiums dramatically (one Chicago hospital recently was notified of a \$100,000 increase in annual premium) and others are limiting coverage only to low risk categories. Some 22 proposals have been developed for presentation and discussion by the ISMS Medical-Legal Council in an attempt to recommend activities which might offset this. In addition, the ISMS-sponsored professional liability insurance program has enrolled over 4,300 members and has accomplished review of incidents to keep premiums in line. Also, the Pilot Program of Arbitration of In-Hospital Claims, under development for nearly two years, is nearing a point of implementation on a trial basis in a small number of hospitals.

Any specific suggestions should be submitted to the ISMS Medical Legal Council, 360 N. Michigan Ave., Chicago, 60601.

**REGIONAL PERINATAL INTENSIVE CARE CENTERS DESIGNATED**—Illinois Department of Public Health Director Joyce C. Lashof, M.D., has announced the designated Regional Perinatal Intensive Care Centers. Downstate hospitals include Rockford Memorial, and St. Francis Hospital, Peoria. Memorial Medical Center and St. Johns in Springfield are developing a combined program for Springfield. Six of the regional centers located in Chicago are: Chicago Lying-in-Hospital, Cook County Hospital, Foster-McGaw Hospital, Northwestern Memorial Hospital, Rush-Presbyterian-St. Luke's Hospital and the University of Illinois Hospital.

**HEW SETS LIMITS ON CHIROPRACTIC SERVICES**—HEW issued final regulations defining the conditions under which Medicare will reimburse for chiropractic services. The coverage is provided only for treatment of "subluxation," that "there must be a malpositioning of a vertebra anatomically demonstrable on an X-ray film," that such a condition can be identified by other disciplines. HEW also states that chiropractors must meet strict educational and professional requirements before their services can be reimbursed under the program.

**NEW ISMS EMPLOYEES**—Donald A. Udstuen is the new Governmental Affairs Division Director. Mr. Udstuen formerly was Assistant to the Speaker of the Illinois House of Representatives, W. Robert Blair. Bob Kjellander has been named Assistant Director of Governmental Affairs.

Edward Stuppy has been advanced to Director of the Public Relations Division. New Executive Assistants in the Division are Edward S. Stecki and Mrs. Carol Gizyn.

Richard Thurman is the new Director of Information Systems for the Illinois Foundation for Medical Care.

Wendy Smith has assumed duties as administrative secretary for the Illinois Psychiatric Society, Illinois Association of Ophthalmology and the Illinois Society of Internal Medicine.

Illinois Council on Continuing Medical Education's new Assistant to the Director is Linda O'Connell.

**PHYSICIANS IN THE NEWS**—Lester A. Nathan, M.D., Skokie, was recently named to the State of Illinois Medical Examining Committee. Dr. Nathan is a practicing pediatrician and an associate in pediatrics at Northwestern University School of Medicine.

John W. Ditzler, M.D., Chicago, is the newly elected President-elect of the American Society of Anesthesiologists.

The Illinois Foundation for Medical Care Board of Trustees has elected Allan Goslin, M.D., Streator, IFMC President. Dr. Goslin will fulfill the unexpired term of Philip G. Thomsen, M.D., Dolton, who resigned due to health reasons. Dr. Goslin is the Second District Representative to the ISMS Board of Trustees. Robert Fox, M.D., Glenview, was chosen to succeed Dr. Goslin as IFMC Vice President.

ISMS President Fredric D. Lake, M.D., Evanston, has been elected Vice Chairman, Board of Chancellors of the American College of Radiology. Dr. Lake will take office April, 1975.

David Rendleman, M.D., Carbondale has been appointed by Governor Walker to serve on the 13-member Health Care Facilities Planning Board. The board, comprised of six provider representatives and seven consumers, will rule on applications to construct, modify or expand health facilities under the new Certificate of Need Law.

**Drs. Bordenave and McDonald  
Receive Tribute**



Dr. Bordenave



Dr. McDonald

The medical staff of Community Hospital, Geneva, recently held a testimonial dinner in honor of Joseph L. Bordenave, M.D. and James A. McDonald, M.D. The family physicians each received plaques inscribed with "In recognition of meritorious service to his fellow physicians through the Illinois State Medical Society."

Dr. Bordenave is the Chairman of the ISMS Board of Trustees and represents the First District as Trustee. Dr. McDonald is serving his second year as Vice Speaker of the ISMS House of Delegates.

**Dr. Milton Miller Honored**



Franklin Boulevard and Central Community Hospitals, Chicago, in conjunction with the State of Israel Bonds paid tribute to Milton Miller, M.D., Wilmette, for his dedication to the medical progression and for his work to insure Israel's economic survival.

Dr. Miller is President of the Medical Staff and Director of Medical Education at Franklin Boulevard and serves on the faculty at Chicago Medical School.

A-H-ROBINS

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## Carcinoma of the Lip

(Continued from page 463)

tient refuses operation or if operation is contraindicated, that patient should be treated by radiotherapy because in at least one-half of these cases, lymph node metastasis can be controlled by radiotherapy. Fairly vigorous treatment is required and it is not the treatment of choice. **Dr. Beal:** I think it's important for the physician to be aware that there are two excellent methods available for treating this lesion. This is one lesion where there is a choice in treatment which sometimes depends in part upon availability. It is important to recognize the advantages and disadvantages of each method of treatment. ▶

## Housestaff News

(Continued from page 430)

Organization is the critical ingredient for improvement of the house officer's education, environment, and patient care. Without organization, unreasonable treatment of housestaff can continue unchecked. If organized, house officers can effectively deal with their administrations maturely and fairly, with improvement in virtually every aspect of the house officer's patient care responsibilities and educational benefits. ▶

## 1415 North Dearborn

Quiet living, Minutes To Loop

1415 North Dearborn

2 Bedrooms 2 Baths

from \$460. Mo.



Free luxuries: carpets, no-frost refrigerator  
drapes, dishwasher, swim club & party.

266-2700

Steven L. Amdur Realty Co., Inc.

### PROLOID® (thyroglobulin)

**Caution:** Federal law prohibits dispensing without prescription.

**Description.** Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine ( $T_4$ ) and Sodium Liothyronine ( $T_3$ ). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of  $T_4$  and  $T_3$  in Proloid (thyroglobulin) is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

**Indications.** Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in non-emergency situations, in an attempt to reduce the size of such goiters.

**Contraindication.** Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

**Warnings.** Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

**Precaution.** As with all thyroid preparations this drug will alter results of thyroid function tests.

**Adverse Reactions.** Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

**Dosage and Administration.** Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR,  $T_3$ ,  $^{131}\text{I}$  resin sponge uptake,  $T_3$ ,  $^{131}\text{I}$  red cell uptake, Thyo Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of  $T_4$  and  $T_3$  is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

**Overdosage Symptoms.** Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

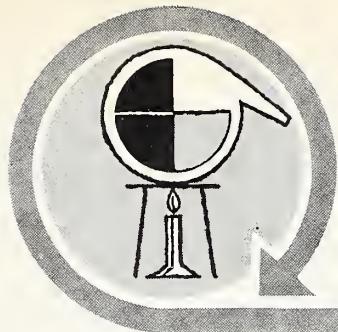
**How Supplied.**  $\frac{1}{4}$  grain;  $\frac{1}{2}$  grain; scored 1 grain;  $1\frac{1}{2}$  grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

Full information available on request.



WARNER CHILCOTT

Division, Warner-Lambert Company  
Morris Plains, New Jersey 07950



# new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**Single Chemicals**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

## The following new drugs have been marketed:

### NEW SINGLE DRUGS

|                      |  |    |
|----------------------|--|----|
| <b>VELOSEF</b>       | Antibiotic   | Rx |
| Manufacturer:        | E. R. Squibb & Sons, Inc.  |    |
| Nonproprietary Name: | Cephadrine   |    |
| Indications:         | Infections of the respiratory tract, the ear, skin, and urinary tract caused by susceptible organisms. |    |
| Contraindications:   | Hypersensitivity to cephalosporins; use with caution in patients susceptible to penicillins.           |    |
| Dosage:              | Follow instructions in package insert.   |    |

Supplied:

Capsules, 250 and 500 mg.  
Oral Suspension, 125 and 250 mg. per 5 cc., reconstituted

### DUPLICATE SINGLE DRUGS

**DYLATE**

Manufacturer:

Nonproprietary Name:

Indications:

Precautions:

Dosage:

Supplied:

Smooth muscle relaxant Rx

Paul B. Elder Company

Papaverine HCl

Cerebral and peripheral ischemia associated with arterial spasm and myocardial ischemia complicated by arrhythmias.

Use with caution in glaucoma. One capsule every 12 hours, increase as required.

Capsules, 150 mg.

**NITROPRN**

Manufacturer:

Nonproprietary Name:

Indications:

Dosage:

Supplied:

Coronary Vasodilator Rx

Warner Chilcott

Nitroglycerin

Acute anginal episodes, management of angina pectoris, coronary artery disease, coronary occlusion, or subacute myocardial infarction.

0.3 to 0.6 mg. sublingually as needed.

Sublingual tablets, 0.3; 0.4; 0.6 mg.

## LOW-COST GROUP INSURANCE ANOTHER **ISMS** MEMBERSHIP PRIVILEGE

**THE GROUP DISABILITY PLAN** • Provides up to \$400.00 weekly in the event of disability caused by Accident or Sickness. • Special Guaranteed renewal feature. • Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** • Pays your office overhead expense when disability strikes. • Premiums are Tax Deductible. • Pays in Addition to the Disability Plan Benefits.

**THE FAMILY MAJOR MEDICAL EXPENSE PLAN** • In or out of Hospital Benefits up to \$25,000.00 per Disability. • Up to \$50.00 Daily Hospital Room and Board maximum • Subject to choice of deductible and 80% coinsurance.

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

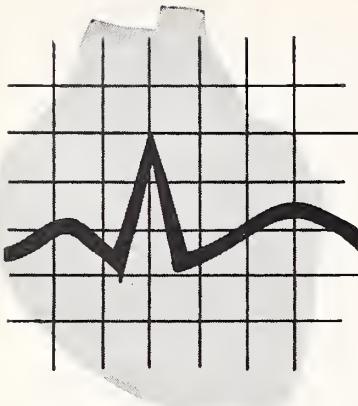
Administrators:

**PARKER, LESAINE & COMPANY**  
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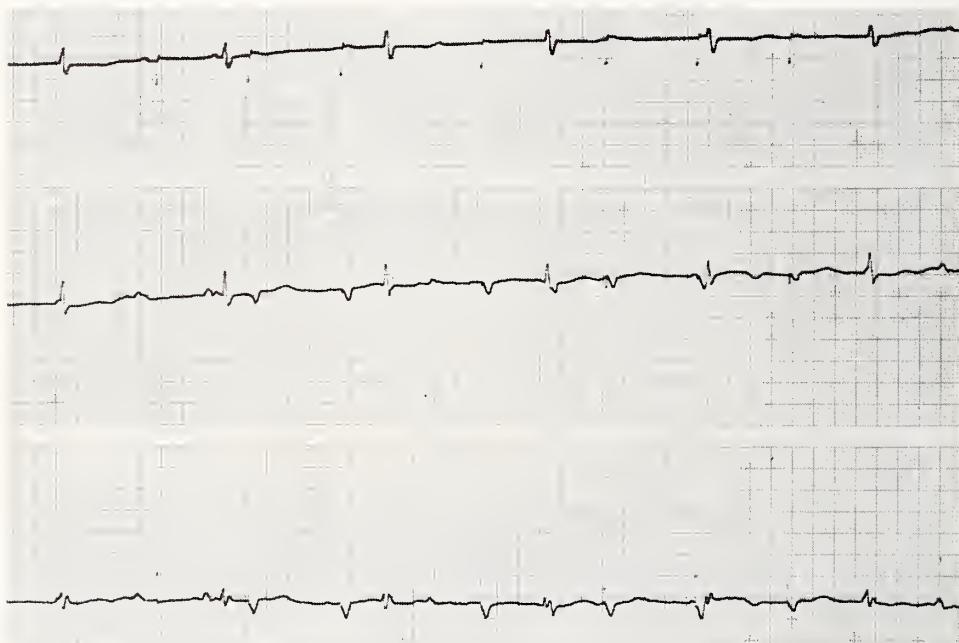
Skokie, Illinois 60076

Phone: 312-679-1000



## EKG of the month

JOHN R. TOBIN, M.D., M.S., RIMGAUDAS, NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
JAMES V. TALANO, M.D., SARAH JOHNSON, M.D. and  
ROLF M. GUNNAR, M.D., M.S./Section of Cardiology,  
Loyola University Stritch School of Medicine



A robust 75-year-old man came to the outpatient department with a recurrence of his symptoms of lightheadedness and weakness. His complaints were worsened by rapid positional changes or exertion. One year ago he had a permanent transvenous pacemaker placed in the apex of his right ventricle for sinus node block and a slow junctional rhythm. The patient was taking his own pulse and reported that the rate fell from 72 to 40 beats/minute two days prior to his visit. The simultaneous lead I, II, and III rhythm strip is shown.

### Questions:

1. The ECG rhythm strip shows:
  - A. Junctional rhythm.
  - B. Pacemaker rhythm on demand.
  - C. Pacemaker failure to capture.
  - D. Complete AV block.
  - E. All of the above.

2. The treatment here should be:
  - A. Pacemaker catheter repositioning.
  - B. Pacemaker removal.
  - C. Atropine intravenously.
  - D. Isuprel intravenously.
  - E. All of the above.

(Answers on page 495)

# The overweight diabetic... trapped by her own fat cells.

If she would diet, her blood sugar might come down. Her high level of blood insulin might come down, too. This may be important to the overweight diabetic since insulin is the "storage hormone" that transports glucose into adipose tissue. Maybe the last thing the overweight diabetic needs to lower blood sugar is a drug that stimulates more insulin secretion. Dieting doesn't work in the overweight, nonketotic, adult-onset diabetic, consider adding DBI-TD.

## DBI-TD® Geigy phenformin HCl

Answers blood sugar without using blood insulin.



### phenformin HCl Tablets of 25 mg.

TD® phenformin HCl

d-Disintegration

Tablets of 50 and 100 mg.

**Actions:** Stable, adult diabetes mellitus; sulfonylurea failures, primary and secondary; add to insulin therapy of unstable diabetes.

**Indications:** Diabetes mellitus that can be controlled by diet alone; hypersensitivity to phenformin; renal disease with impaired renal function; history of lactic acidosis; alcoholism; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, ketoacidosis, infection, gangrene); during or immediately after surgery where insulin is indispensable; prehepatic disease; cardiovascular collapse (shock); after disease states associated with hypoxemia.

**Warnings:** Lactic Acidosis: There have been numerous reports of lactic acidosis in patients taking phenformin. This is an often fatal metabolic acidosis, characterized by elevated lactate levels, an increased lactate-to-pyruvate ratio, and decreased blood pH. In most cases, hypoxemia ranging from mild to severe was present. This may have been the result of dehydration. In some patients who developed lactic acidosis, serum creatinine was later within normal limits when the patients were properly hydrated. Observe the following specific warnings: Impairment of renal function increases the risk of lactic acidosis. Perform renal function tests, such as serum creatinine, prior to phenformin therapy and annually thereafter. Phenformin is contraindicated in patients with impaired renal function. Cardiovascular collapse (shock), congestive

heart failure, acute myocardial infarction, and other conditions characterized by hypoxemia have been associated with lactic acidosis and also may cause prerenal azotemia. Use of phenformin in patients likely to develop such conditions must be carefully considered. Discontinue phenformin promptly when such events occur.

c. Gastrointestinal disturbances are the most common adverse reactions of phenformin therapy and must be distinguished from the prodrome of lactic acidosis. Anorexia and mild nausea are not uncommon side effects, particularly upon initiation of therapy. Nausea, vomiting, malaise, or abdominal pain may herald the onset of lactic acidosis. Instruct the patient to notify the physician immediately should any of these symptoms or hyperventilation occur. Withdraw phenformin until the situation is clarified by determination of electrolytes, and, if necessary, pH, blood sugar, ketones, lactate, and pyruvate.

d. Lactic acidosis has a significant mortality. When suspected, discontinue phenformin and institute bicarbonate infusions and other appropriate therapy, even before the results of lactate determinations are available. It should be suspected in the presence of a metabolic acidosis in any diabetic patient lacking evidence of ketoacidosis (ketonuria and ketonemia) and not intoxicated with methanol or salicylates, or not in uremic acidosis.

e. Use special caution after initiation of phenformin therapy, after increase of drug dosage, and in circumstances that may cause dehydration leading to impaired renal function.

f. Warn patients against using alcohol in excess while receiving phenformin, since ethanol and phenformin potentiate the tendency of each

to cause an elevation of blood lactate levels. **Pregnancy:** Use during pregnancy is to be avoided.

**Precautions:** Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria, in spite of relatively normal blood sugar with little or no urinary sugar. This may result from excessive phenformin therapy or insufficient carbohydrate intake.

**"Destabilization" of Previously Controlled Diabetic:** When laboratory abnormalities or clinical illness develop, evaluate electrolytes, pH, lactate, pyruvate, and blood and urine ketones for evidence of ketoacidosis or lactic acidosis. With either form, withdraw phenformin and institute corrective therapy.

**Hypoglycemia:** Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

**Adverse Reactions:** Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.

(B) 98-146-103-G (8/74)

*For complete details, including dosage, please see full prescribing information.*

GEIGY Pharmaceuticals  
Division of CIBA-GEIGY Corporation  
Ardsley, New York 10502

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
360 No. Michigan Ave. • Chicago, IL 60601 • (312) 782-1654



*Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.*

*If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events.*

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## December, 1974

### Cancer

#### CARCINOMA OF THE BREAST

For: All Physicians. Symposium, Dec. 3, 1974, 8:30 AM, Westlake Community Hosp., Melrose Park, Ill. Speaker: S. G. Economou, M.D., Rush Med. Ctr. CME Credit: 1½ hrs. AMA Category 2. Sponsor, contact: Westlake Community Hosp., 1225 Superior St., Melrose Park, IL 60160.

#### TUMOR BOARD

For: All Physicians. Bi-monthly meeting, Dec. 17, 1974, 8:30 AM, Westlake Community Hosp., Melrose Park, Ill. CME Credit: 1 hr. AMA Category 2. Sponsor, contact: Westlake Community Hosp., 1225 Superior St., Melrose Park, IL 60160.

### Cardiovascular

#### ACUTE CARDIAC CARE

For: Family Physicians. 3-day course, Dec. 4-6, 1974, Chicago. CME Credit: 21 hrs. AMA Category 1. Fee: \$125. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

#### PROPRANOLOL & OTHER AGENTS IN ANGINA

For: All Physicians, Allied Health. Weekly seminar, Dec. 10, 1974, Memorial Hosp. of DuPage Co., Elmhurst, Ill. Speaker: Oglesby Paul, M.D. CME Credit: 1 hr. AMA Category 1. Sponsor, contact: J. H. Huss, M.D., Dir. Med. Educ., Memorial Hosp. of DuPage Co., Avon Rd. & Schiller St., Elmhurst, Ill. 60126.

#### CARDIAC CLINIC

For: All Physicians. Monthly meeting, Dec. 10, 1974, 8:30 AM, Westlake Community Hosp., Melrose Park, Ill. CME Credit: 1 hr. AMA Category 2. Sponsor, contact: Westlake Community Hosp., 1225 Superior St., Melrose Park, IL 60160.

#### LETHAL DISEASES OF THE ASCENDING AORTA & BRANCHES

For: All Physicians. Frontiers of Medicine Lecture, Dec. 11, 1974, 9:00 AM, Billings Hosp., Univ. of Chicago. CME Credit: 6 hrs. AMA Category 1, AAFP. Fee: \$30. Sponsor, contact: Frontiers of Medicine, Univ. of Chicago, Box 451, 950 E. 59th St., Chicago, IL 60637.

### Family Medicine

#### PSYCHIATRY FOR THE NON-Psychiatrist

For: All physicians. Lecture, Dec. 11, 1974, 12:30 PM, Community Hospital, Geneva, Ill. Speaker: H. Strassman, M.D., Chicago Med. Sch. CME Credit: 3 hrs. AMA Category 1, AAFP Elective. Sponsor, contact: Community Hosp., 416 S. Second St., Geneva, IL 60134.

#### SYMPHOSIUM ON SHOCK

For: All Physicians. 2-day symposium, Dec. 13-14, 1974, Chicago. CME Credit: 10 hrs. AMA Category 1. Fee: \$75. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

### General Medicine

#### GENERAL MEDICINE LECTURE SERIES—PART I

For: All physicians & house staff. Weekly lecture series, Dec. 3, 10, & 17, 1974, St. Mary of Nazareth Hosp. Ctr., Chicago. CME Credit: 1½ hrs. each, AAFP Elective. Sponsor, contact: St. Mary of Nazareth Hosp. Ctr., Dept. of Med. Educ., 1120 N. Leavitt St., Chicago, IL 60622.

### Internal Medicine

#### INTRARENAL DISTRIBUTION OF ANTIBIOTICS IN HEALTH & DISEASE

For: All Physicians, Nurses. Lecture, Dec. 5, 1974, 11:00 AM, Martha Washington Hosp., Chicago. Speaker: Andrew Whelton, M.D., Johns Hopkins Hosp. CME Credit: 1 hr. AMA Category 1, AAFP. Sponsor, contact: F. Lopez-Fernandez, M.D., Med. Dir., Martha Washington Hosp., 4055 N. Western, Chicago, 60618.

### INFLAMMATORY BOWEL DISEASE

For: All Physicians. Lecture, 7:30 pm, Dec. 10, Sherman Hosp., Elgin, IL. Speaker: A. A. Serritella, M.D., Dept. of Gastroenterology, Lutheran General Hosp., Park Ridge, IL. CME Credit: 2 hrs., AMA Category 1. Sponsor, contact: W. E. Gasser, M.D., Sherman Hosp., 934 Center, Elgin, IL 60120.

### Obstetrics/Gynecology

#### BASIC OBSTETRICS

For: Family Physicians. 1-week course, Dec. 2-6, 1974, Chicago. CME Credit: 35 hrs. AMA Category 1. Fee: \$200. Reg. Limit: 50. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

#### SURGICAL & RADIATION THERAPY OF GYNECOLOGICAL MALIGNANCIES

For: Specialists. 1-week course, Dec. 9-13, 1974, Chicago. CME Credit: 30 hrs. AMA Category 1. Fee: \$200. Reg. Limit: 16. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

### Pediatrics

#### CURRENT PEDIATRIC MANAGEMENT

For: All Physicians. Short course/workshop, Dec. 4, 1974, Indianapolis. CME Credit: 6 hrs. AMA Category 1, AAFP. Fee: \$35. Sponsor, contact: Postgrad. Med. Educ., Indiana Univ. Sch. of Med., 1100 W. Michigan, Indianapolis, IN 46202.

### Psychiatry

#### RECENT ADVANCES IN PSYCHIATRY

For: Psychiatrists. 5-day Course, Dec. 2-6, Chicago. CME Credit: 39½ hrs. AMA Category 1. Fee: \$200. Reg. Limit: 80. Sponsor, contact: Cook County Grad. School of Med., 707 S. Wood, Chicago 60612.

### Respiratory Disease

#### FUNGAL DISEASES OF THE LUNG

For: All Physicians, Nurses. Lecture, Dec. 18, 1974, 11:00 AM, Martha Washington Hosp., Chicago. Speaker: R. Briney, M.D., Suburban Hosp. & Sanitorium. CME Credit: 1 hr. AMA Category 1, AAFP Prescribed. Sponsor, contact: F. Lopez-Fernandez, M.D., Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chicago 60618. Co-sponsor: Chicago Lung Assn.

## Recent CME Accreditations

The ISMS Committee on CME Accreditations has recently approved the CME programs of these institutions:

**Belleville Hospital Association for CME (Memorial Hospital & St. Elizabeth Hospital)**

**Sherman Hospital, Elgin**

**South Chicago Community Hospital, Chicago**

**St. Elizabeth, Chicago**

### Surgery

#### SURGERY OF TRAUMA

For: All Physicians. 4-day course, Dec. 9-12, 1974, Chicago. CME Credit: 28 hrs. AMA Category 1. Fee: \$175. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

#### SPECIALTY REVIEW SURGERY, PART II

For: Surgeons. 2-week course, Dec. 2-13, 1974, Chicago. CME Credit: 99 hr. AMA Category 1. Fee: \$350. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

#### SPECIALTY REVIEW—THORACIC SURGERY

For: Surgeons. 1-week course, Dec. 9-13, 1974, Chicago. CME Credit: 40 hrs. AMA Category 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

#### SURGICAL ASPECTS OF CANCER OF THE COLON

For: Physicians. Nurses. Lecture, Dec. 11, 1974, 11:00 am, Martha Washington Hosp., Chicago. Speaker: R. W. Seed, M.D., Chairman, Dept. of Surgery, Grant Hosp. CME Credit: 1 hr., AAFP Prescribed, AMA Category 1. Reg. Limit: 106. Co-sponsor: American Cancer Society. Sponsor, contact: Martha Washington Hosp., 4055 N. Western, Chicago 60618.

#### BREAST CANCER

For: All physicians. Group Discussions, Lecture, Dec. 6, Amer. Hosp., 10 AM; Dec. 6, Lincolnwood Hyatt House, 6 PM; Dec. 7, Bethesda Hosp., 10 AM. Speaker: J. A. Van Heerden, M.D., Mayo Clinic. CME Credit: 5 hrs. AAFP, AMA Category 1. Fee: \$10 (other than staff for dinner). Deadline: Dec. 2. Sponsor contact: P. Pierdick, FABP/CME, Amer. Hosp., 850 W. Irving, Chicago 60613, (312) 525-6780.

### Trauma

#### URINARY TRACT INJURY ASSOCIATED WITH PELVIC TRAUMA

For: All Physicians, Allied Health. Weekly seminar, Dec. 3, 1974, Memorial Hosp. of DuPage Co., Elmhurst, Ill. Speaker: S. Clark, M.D., Univ. of Illinois. CME Credit: 1 hr. AMA Category 1. Sponsor, contact: J. H. Huss, M.D., Dir. Med. Educ., Memorial Hosp. of DuPage Co., Avon Rd. & Schiller St., Elmhurst, IL 60126.

### Urology

#### SPECIALTY REVIEW COURSE IN UROLOGIC PATHOLOGY & X-RAY

For: Urologists. 2½ day Course, Dec. 5-7, Chicago. CME Credit: 20 hrs., AMA Category 1. Fee: \$100. Reg. Limit: 75. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood, Chicago 60612.

## January, 1975

### Cancer

#### CURRENT CONCEPTS IN CANCER CHEMOTHERAPY & IMMUNOTHERAPY

For: All physicians. Short course, Jan. 15, 1975, Indianapolis. CME Credit: 6 hrs. AAFP, AMA Category 1. Fee: \$35. Sponsor, contact: Postgrad. Med. Educ., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis 46202.

### Endocrinology

#### ADVANCES IN ENDOCRINOLOGY

For: All physicians. Frontiers of Medicine Lecture, Jan. 8, 1975, Billings Hospital, Chicago. CME Credit: 3 hrs. AAFP, AMA Category 1. Fee: \$20. Sponsor, contact: Frontiers of Med., Univ. of Chicago, Box 451, 950 E. 59th St., Chicago, IL 60637.

**OFFICE GYNECOLOGY**

For: Family Physicians. 5-day course, Jan. 20-24, 1975, Chicago. CME Credit: 32½ hrs., AMA Category 1. Fee: \$175. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

**FIBEROPTIC SOLONOSCOPY**

For: All Physicians. 3-day Course, Jan. 22-24, Chicago. CME Credit: 19 hrs., AMA Category 1. Fee: \$250. Reg. Limit: 10. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood, Chicago 60612.

**MANAGEMENT OF COMMON PSYCHIATRIC PROBLEMS**

For: All Physicians. Lecture, Jan. 21, 7:30 PM, Sherman Hosp., Elgin, IL. CME Credit: 2 hrs., AMA Category 1. Speaker: T. G. Esau, M.D., Lutheran General Hosp., Park Ridge, IL. Sponsor, contact: CME Committee, Sherman Hosp., 934 Center, Elgin, IL 60120.

**FAMILY PRACTICE REVIEW (WITH SPECIAL ED. PROGRAM FOR SPOUSES)**

For: Family Practitioners. 5-day Workshop-Course, Jan. 20-24, Ann Arbor, MI. CME Credit: 35 hrs., AMA Category 1, AAFP, AOA elective. Fee: \$150. Sponsor, contact: R. K. Richards, Director, Office of Intramural Ed., Towsley Center, U. of M. Ann Arbor, MI 48104.

*General Medicine***TREATMENT & DIAGNOSIS OF THYROID DISORDERS**

For: All Physicians. Grp. Discussion & Lectures, Jan. 17, 10:00 AM, Bethesda Hosp.; Jan. 17, 6:00 PM, Lincolnwood Hyatt House; Jan. 18, 10:00 AM, S. R. Forkosh Hosp., Chicago. Speaker: C. A. Gorman, MD., Mayo Clinic. CME Credit: 5 hrs., AAFP. Sponsor, contact: Neil Glass, Bethesda Hosp., 2451 W. Howard Chicago 60645, (312) 761-6000.

**GENERAL MEDICINE LECTURE SERIES—PART II**

For: House Staff & General Staff. Weekly Lecture Series, Jan. 7, 14, 21, & 28, St. Mary of Nazareth, Chicago. CME Credit: 18 hrs., AAFP Elective. Sponsor, contact: Anthony Sapienza, M.D., St. Mary of Nazareth Hosp., 1120 N. Leavitt, Chicago 60622.

*Obstetrics & Gynecology***OFFICE GYNECOLOGY**

For: General Practice & Part Time Specialty. 5-day Course, Jan. 20-24, Chicago. CME Credit: 32½ hrs., AMA Category 1. Fee: \$175. Reg. Limit: 80. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood, Chicago 60612.

*Ophthalmology***OCULAR HISTOPLASMOSIS**

For: Specialists. 2-day workshop, Jan. 30-31, 1975, Airport Hilton, Indianapolis. CME Credit: 14 hrs., AAFP, AMA Category 1. Fee: \$200. Sponsor, contact: Postgrad. Med. Educ., Indiana Univ. Sch. of Med., 1100 W. Michigan, Indianapolis, IN 46202.

*Pharmacology***CLINICAL PHARMACOLOGY IN CONGESTIVE HEART FAILURE**

For: All Physicians & Nurses. Lecture, Jan. 19, 11:00 AM, Martha Washington Hosp., Chicago. Speaker: A. Brest, M.D., Jefferson Med. College, Philadelphia. CME Credit: 1 hr., AMA Category 1, AAFP Prescribed. Reg. Limit: 106, Sponsor, contact: Martha Washington Hosp., 4055 N. Western, Chicago 60618.

*Psychiatry***CURRENT & FUTURE PERSPECTIVES IN TREATMENT EVALUATION**

For: All physicians. Lecture, Jan. 15, 1975, 7:30 PM, Forest Hosp. Professional Ctr., Des Plaines, IL. Speaker: T. Kiresuk, Ph.D., Minneapolis. Fee: \$15 (\$5 students). Sponsor, contact: Forest Hospital, 555 Wilson Lane, Des Plaines, IL 60616; (312) 827-8811.

**MUTUAL RESPECT APPROACH TO CHILD GUIDANCE**

For: Pediatricians Monthly Meeting, Jan. 21, 6:00 PM, John Hancock Bldg., N. Mich. Ave., Chicago. Dinner reservations: \$12.00. Sponsor: Chicago Pediatric Society. Contact: Lowell M. Zollar, M.D., 121 W. 154th Harvey, IL 60426.

*Surgery***FIBEROPTIC COLONOSCOPY**

For: All Physicians. 3-day Course, Jan. 22-24, Chicago. CME Credit: 19 hrs., AMA Category 1. Fee: \$250. Reg. Limit: 10. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood, Chicago 60612.

**FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY**

For: Surgeons. 3-day Course, Jan. 27-29, Chicago. CME Credit: 19½ hrs., AMA Category 1. Fee: \$250. Reg. Limit: 10. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood, Chicago 60612.

**MEDICINE FOR TODAY—Spring Sessions**

**For:** All practicing physicians, house staff. IAFP's 26th Annual Lecture Series, with A-V and Q&A supplement. Emphasis on Orthopedics, Psychiatry, Endocrinology, & Pulmonary Function. **CME Credit:** 30 hrs. (maximum, for Fall, 1974, & Spring 1975 sessions) AAFP Prescribe, AMA Category 1. **Fee:** \$90 AAFP mbrs., \$100 non-mbrs. Meets in these cities on dates noted:

**Belleville**—Feb. 13, 20, 27, Mar. 6, 13, 20.

**Berwyn**—Feb. 12, 19, 26, Mar. 5, 12, 19.

**Centralia**—Feb. 19, Mar. 5, 19.

**Champaign**—Feb. 13, 27, Mar. 13.

**Chicago Nearwest**—Feb. 12, 19, 26, Mar. 5, 12, 19.

**Chicago North**—Feb. 12, 19, 26, Mar. 5, 12, 19.

**Chicago Southwest**—Feb. 12, 19, 26, Mar. 5, 12, 19.

**Harvey**—Feb. 12, 19, 26, Mar. 5, 12, 19.

**Hinsdale**—Feb. 12, 26, Mar. 12.

**Melrose Park**—Feb. 12, 19, 26, Mar. 5, 12, 19.

**Park Ridge**—Feb. 12, 19, 26, Mar. 5, 12, 19.

**Peoria**—Feb. 13, 27, Mar. 13.

**Rockford**—Feb. 13, 20, 27, Mar. 6, 13, 20.

**Rock Island**—Feb. 13, 27, Mar. 13.

**Springfield**—Feb. 20, Mar. 6.

For details of time and place, contact: Ill. Academy Family Phys., 14 E. Jackson Blvd., Suite 1532, Chicago, IL 60604.

*February, 1975**Cardiology***EKG DIAGNOSIS**

For: Physicians—Gen. Interest. 3-day Workshop-Course, Feb. 18-20, U. of Mich., Ann Arbor. CME Credit: 21 hrs., AMA Category 1, AAFP Elective, AOA Elective. Fee: \$120. Sponsor: Am. College of Emergency Physicians. Contact: Robt. K. Richards, Director, Office of Intramural Education, Towsley Center, U. of Mich., Ann Arbor, MI 48104.

*Dermatology***EVERYDAY DERMATOLOGY**

For: Specialists. Short Course, Feb. 19, Indiana U. Sch. of Med., Indianapolis. CME Credit: 6 hrs., AMA Category 1, AAFP. Fee: \$35. Sponsor, contact: Indiana U. Sch. of Med., 1100 W. Michigan, Indianapolis, IN 46202.

*Emergency Medicine***EMERGENCY MEDICINE**

For: Emergency Physicians. 4-day Workshop-Course, Feb. 25-28, 8:00 AM-5:00 PM, U. of Mich., Ann Arbor. CME Credit: 28 hrs., AMA Category 1, AAFP Elective, AOA Elective. Fee: \$150. Sponsor: Am. College of Emergency Physicians. Contact: Robt. K. Richards, Director, Office of Intramural Education, Towsley Center, U. of Mich., Ann Arbor, MI 48104.

**MEDICAL-LEGAL ASPECTS OF MEDICINE**

For: Physicians. Lecture, Feb. 18, 7:30 PM, Sherman Hosp., Elgin, IL. CME Credit: 2 hrs., AMA Category 1. Sponsor, contact: CME Committee of Sherman Hosp., 934 Center, Elgin, IL 60120.

**REFRESHER COURSE FOR THE FAMILY PHYSICIAN**

For: Family Physicians. 4-day Course, Feb. 11-14, U. of Iowa. CME Credit: 27 hrs., AMA Category 1, AAFP Prescribed, CEU. Fee: \$120. Sponsor: Iowa Acad. of Family Physicians. Contact: U. of Iowa College of Med., Office of CME, U. of Iowa, 101 CMAB, Iowa City, Iowa 52242.

*Gastroenterology***PRACTICAL EXPERIENCES IN GASTROINTESTINAL ENDOSCOPY**

For: Physicians and G.I. Assistants. Combined phys. & asst. 1st day, separate Seminars and Workshops, 2nd day, Feb. 21-22, Playboy Club, Lake Geneva, WI. CME Credit: 14 hrs., AAFP. Fees: \$200 (Phys.), \$75 (G.I. asst.). Deadline: Feb. 18. Sponsor, contact: The Medical College of Wis., 561 N. 15th, Milwaukee, WI 53233.

*Internal Medicine***DIABETES MELLITUS-PATHOGENESIS, PRACTICAL ASPECTS OF MANAGEMENT**

For: All Physicians. Short Course, Feb. 27, Richmond, Ind. CME Credit: 6 hrs., AMA Category 1, AAFP. Fee: \$35. Sponsor, contact: Postgrad. Med. Ed., Indiana Sch. of Med., Fesler Hall, 1100 W. Michigan, Indianapolis, IN 46202.

**NEW DEVELOPMENT IN DIAGNOSIS AND MANAGEMENT OF LIVER DISEASES**

For: All Physicians. Feb. 12, U. of Chicago. CME Credit: 6 hrs., AMA Category 1, AAFP. Fee: \$30. Sponsor, contact: U. of Chicago, Frontiers of Med., 950 E. 59th, Box 451, Chicago 60637.

*Obstetrics & Gynecology***GYNECOLOGICAL LAPAROSCOPY**

For: Gynecologists and Obstetricians. 3-day Course, Feb. 5-7, Chicago. CME Credit: 18 hrs., AMA Category 1. Fee: \$250. Reg. Limit: 8. Sponsor, contact: Cook County Sch. of Med., 707 S. Wood, Chicago 60612.

*Pathology***AGING AND MALIGNANCY OF THE ORAL MUCOSA**

For: Dentists, Physicians, Pathologists. Symposium, Feb. 5-7, 8:30 AM-12:30 PM, Camino Real Hotel, Mexico City, Mexico. Co-sponsor: Mexico Dental Society. Speaker: P. D. Toto, D.D.S., Orban-Loyola Memorial. Fee: \$50. Reg. Limit: 100, Deadline: Jan. 1. Sponsor, contact: P. D. Toto, D. S. or A. W. Gargiulo, D.D.S., Orban-Loyola Memorial, 2160 S. First, Maywood, IL 60153.

*Pediatrics***SPECIALTY REVIEW COURSE IN PEDIATRIC SURGERY**

For: Pediatricians. 5-day Course, Feb. 17-21, Chicago. CME Credit: 38 hrs., AMA Category 1. Fee: \$200. Reg. Limit: 85. Sponsor, contract: Cook County Grad. Sch. of Med., 707 S. Wood, Chicago 60612. (No Title Available)

For: Pediatricians & Physicians. Monthly Meeting, Feb. 18, Dinner 7:00 PM, Program 8:00 PM, Sheraton-Blackstone Hotel, Chicago. Fee: \$12.00 (dinner). Co-sponsor: Institute of Medicine of Chicago. Sponsor, contact: L. M. Zollar, M.D., Chicago Pediatric Society, 121 West 154th, Harvey, IL 60426.

*Psychiatry***CURRENT AND FUTURE PERSPECTIVES IN BEHAVIOR MODIFICATION**

For: Psychiatrists. Lecture, Feb. 19, Forest Hosp., Des Plaines, IL. Speaker: I. Goldiamond, Ph.D., U. of Chicago. Fee: \$15 (Student rate: \$5). Sponsor: Forest Hosp., 555 Wilson Ln., Des Plaines, IL 60016. Contact: June Bengtsen, PR Dept. (312) 827-8811. X362.

**4TH ANNUAL FRED H. PRIEBE MEMORIAL SYMPOSIUM ON ARTHRITIS**

For: All Physicians. Short Course, Feb. 5, Indianapolis. CME Credit: 6 hrs., AMA Category 1, AAFP. Fee: \$35. Co-sponsor: Arthritis Foundation-Indiana Chapter. Sponsor, contact: Postgrad. Med. Ed. Indiana Univ. Sch. of Med., Fesler Hall, 1100 W. Michigan, Indianapolis, IN 46202.

*Surgery***SPECIALTY REVIEW COURSE IN PEDIATRIC SURGERY**

For: Pediatric Surgeons. 5-day Course, Feb. 17-21, Chicago. CME Credit: 38 hrs., AMA Category 1. Fee: \$200. Reg. Limit: 150. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood, Chicago 60612.

# IN GONORRHEA INJECTION

## Wycillin® (STERILE PROCAINE PENICILLIN G SUSPENSION) WYETH

**Gonorrhea**, according to the national Center for Disease Control, is, if the parenteral route is chosen, most effectively treated with aqueous procaine penicillin G. In uncomplicated cases, administration of 4.8 million units together with 1 gram oral probenecid, given at least 30 minutes prior to injection, is recommended.

**Indications:** In treatment of moderately severe infections due to penicillin G-sensitive microorganisms sensitive to the low and persistent serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

**NOTE:** When high sustained serum levels are required use aqueous penicillin G, IM or IV.

The following infection will usually respond to adequate dosages of intramuscular procaine penicillin G.—*N. gonorrhoeae*: acute and chronic (without bacteremia).

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

**Contraindications:** Previous hypersensitivity reaction to any penicillin.

**Warnings:** Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy.

•Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen and intravenous corticosteroids should also be administered as indicated.

Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents e.g., pressor amines, antihistamines and corticosteroids.

**Precautions:** Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injections may produce neurovascular damage.

A small percentage of patients are sensitive to procaine. If there is a history of sensitivity, make the usual test: Inject intradermally 0.1 cc. of a 1 to 2 percent procaine solution. Development of an erythema, wheal, flare or eruption indicates procaine sensitivity. Sensitivity should be treated by the usual methods,

including barbiturates, and procaine penicillin preparations should not be used. Antihistaminics appear beneficial in treatment of procaine reaction.

The use of antibiotics may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections due to bacteria or fungi appear during therapy, discontinue penicillin and take appropriate measures.

If allergic reaction occurs, withdraw penicillin unless, in the opinion of the physician, the condition being treated is life threatening and amenable only to penicillin therapy.

When treating gonococcal infections with suspected primary or secondary syphilis, perform proper diagnostic procedures, including darkfield examinations. In all cases in which concomitant syphilis is suspected, perform monthly serological tests for at least four months.

**Adverse Reactions:** (Penicillin has significant index of sensitization) skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported. (See "Warnings.")

As with other antisiphilitics, Jarisch-Herxheimer reaction has been reported.

**Administration and Dosage:** Administer only by deep intramuscular injection, in upper outer quadrant of buttock. In infants and small children, midlateral aspect of thigh may be preferable. When doses are repeated, vary injection site. Before injection, aspirate to be sure needle bevel is not in blood vessel. If blood appears, remove needle and inject in another site.

Although some isolates of *Neisseria gonorrhoeae* have decreased susceptibility to penicillin, this resistance is relative, not absolute, and penicillin in large doses remains the drug of choice. Physicians are cautioned not to use less than recommended doses.

Gonococcal infections (uncomplicated)—Men or Women: 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to injection.

**NOTE:** Treatment of severe complications of gonorrhea should be individualized using large amounts of short-acting penicillin. Gonococcal endocarditis should be treated intensively with aqueous penicillin G. Prophylactic or epidemiologic treatment for gonorrhea (male and female) is accomplished with same treatment schedules as for uncomplicated gonorrhea.

**Retreatment:** The National Center for Disease Control, Venereal Disease Branch, U.S. Dept. H.E.W. recommends:

Test cure procedures at approximately 7-14 days after therapy. In the male, a gram-stained smear is adequate if positive; otherwise, a culture specimen should be obtained from the anterior urethra. In the female, culture specimens should be obtained from both the endocervical and anal canal sites.

Retreatment in males is indicated if urethral discharge persists 3 or more days following initial therapy and smear or culture remains positive. Follow-up treatment consists of 4.8 million units I.M. divided in 2 injection sites at single visit.

In uncomplicated gonorrhea in the female, retreatment is indicated if follow-up cervical or rectal cultures remain positive for *N. gonorrhoeae*. Follow-up treatment consists of 4.8 million units daily on 2 successive days.

Syphilis: all gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

**Composition:** Each TUBEX® disposable syringe 2,400,000 units (4-cc size) contains procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer, and as w/v approximately 0.7% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. The multiple-dose 10-cc. vial contains per cc. 300,000 units procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer and approximately 7 mg. lecithin, 2 mg. carboxymethylcellulose, 3 mg. polyvinylpyrrolidone, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

# Five are graduating with honors. How many with VD?

On the average, you can figure the incidence of VD among teenagers at about 900 per 100,000 population\*. And growing.

Among those in the 20-24 age-group, the incidence is even higher. And it, too, is growing.

In the long run, a populace educated to the risks and prevention of VD is probably the best answer to the problem. Meanwhile, though, adequate doses of the recommended types of penicillin remain a formidable weapon.

# IN SYPHILIS INJECTION

## Bicillin<sup>®</sup> LONG- ACTING (STERILE BENZATHINE PENICILLIN G SUSPENSION) WYETH

**Syphilis** is preferably treated with benzathine penicillin G, which is also the drug of choice for prophylaxis after exposure. Administration of 2.4 million units (1.2 million in each buttock) usually cures most cases of primary, secondary and latent syphilis with negative spinal fluid.

**Indications:** In treatment of infections due to penicillin G-sensitive microorganisms that are susceptible to the low and very prolonged serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

The following infections will usually respond to adequate dosage of intramuscular benzathine penicillin G.—Venereal infections: Syphilis, yaws, bejel and pinta.

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

**Contraindications:** Previous hypersensitivity reaction to any penicillin.

**Warnings:** Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens.

Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

**Precautions:** Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism; otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of non-susceptible organisms including fungi. Take appropriate measures should superinfection occur.

**Adverse Reactions:** Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high doses of parenteral penicillin.

As with other antisiphilitics, Jarisch-Herxheimer reaction has been reported.

**Administration and Dosage:** Venereal infections—

Syphilis—Primary, secondary and latent—2.4 million units (1 dose).

Late (tertiary and neurosyphilis)—2.4 million units at 7 day intervals for three doses.

Congenital—under 2 years of age, 50,000 units/Kg, body weight; ages 2-12 years, adjust dosage based on adult dosage schedule.

**(Shake multiple-dose vial vigorously before withdrawing the desired dose.)**

Administer by **deep intramuscular injection** in the upper outer quadrant of the buttock. In infants and small children, the midlateral aspect of the thigh may be preferable. When doses are repeated, vary the injection site. Before injecting the dose, aspirate to be sure needle bevel is not in a blood vessel. If blood appears, remove the needle and inject in another site.

**Composition:** 2,400,000 units in 4-cc. single dose disposable syringe. Each TUBEX disposable syringe also contains in aqueous suspension with sodium citrate buffer, as w/v approximately 0.5% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. Units benzathine penicillin G (as active ingredient); 300,000 units per cc.—10-cc. multi-dose vial. Each cc. also contains sodium citrate buffer, approximately 6 mg. lecithin, 3 mg. polyvinylpyrrolidone, 1 mg. carboxymethylcellulose, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

### Wyeth Laboratories

Philadelphia, Pa. 19101



## Experience With the Halo and Body Cast . . .

(Continued from page 461)

drainage from the scalp about the pins. One had two pins removed and new sterile pins placed through adjacent holes in the halo under local anesthesia in the office  $3\frac{1}{2}$  weeks after initial halo application. The other had one pin replaced under local anesthesia in the office six weeks after the initial halo application. All pin tracts closed uneventfully and drainage ceased. Care was taken not to tighten any pins through the outer table of the skull and thus avoid penetration of the dura.

### Summary

The halo cervical brace and body cast has been useful in the ambulatory treatment of 11 cervical spine fractures. The halo and body cast provide rigid fixation of the cervical spine. By allowing ambulation, the patient's body phys-

iology is better preserved. Earlier hospital discharge is possible with resulting lower costs to the patient and the community. The method is most applicable to cervical spine fractures with no neurologic impairment. Complications directly attributable to the halo have been minimal in our series of patients with cervical spine fractures. ▶

### References

1. Perry, J. and Nickel, V. L.: Total Cervical Spine Fusion for Neck Paralysis. *J. Bone and Joint Surg.*, 41A: 37-59, Jan. 1959.
2. James, J. I. P.: Fracture Dislocation of the Cervical Spine. *J. Royal Coll. Surg., Edinburgh*, 5:232, 1960.
3. Thompson, H.: The "Halo" Traction Apparatus. A Method of External Splinting of the Cervical Spine after Injury. *J. Bone and Joint Surg.*, 44B: 655-661, Aug. 1962.
4. Nickel, V. L.; Perry, J.; Garrett, A.; and Heppenstall, M.: The Halo. *J. Bone and Joint Surg.* 50A: 1400-1409, Oct. 1968.
5. Perry, J.: The Halo in Spinal Abnormalities. *Orthopedic Clinics of No. America*, Vol. 3, No. 1: 69-80, Mar. 1972.
6. Prolo, D. J.; Runnels, J. B.; and Jameson, R. M.: The Injured Cervical Spine. *JAMA*, 224: 591-594, Apr. 1973.

The advertisement features a central diamond-shaped logo containing the number '75' above the word 'YEARS'. Below this, the words 'Professional Protection' are written in a large, flowing script font. Underneath that, 'CONTINUOUSLY' is written in bold capital letters, followed by 'Since 1899'. Below this, the company name 'THE MEDICAL PROTECTIVE COMPANY' is displayed in a bold, serif font, with 'THE' in smaller letters above 'MEDICAL PROTECTIVE COMPANY'. At the bottom, 'FORT WAYNE, INDIANA' is written in a smaller, bold, serif font. The entire advertisement is set against a dark background with a light-colored rectangular border.

CHICAGO AREA OFFICE:  
T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives  
815 Commerce Drive, Suite 102, Oak Brook, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative  
426½ South Fifth Street, Springfield 62701 (217) 544-2251

## **Abstracts Of Board Of Trustees Action**

(Continued from page 425)

will include representatives from industry and the financial community as well as physicians and hospital administrators.

### **Change in Spring Board Meeting Date**

The Board of Trustees will meet May 17-18, 1975, at the Marriott Hotel, Chicago, instead of May 31-June 1 as previously announced. The annual Journalism Awards banquet will be held in conjunction with this meeting. In a related action, the Board authorized the presentation of cash awards in 1975, rather than the traditional trophies, for excellence in medical journalism.

### **Allocation of AMA-ERF Funds**

The Board will introduce a resolution urging the House of Delegates to continue its \$10 per member allocation of AMA-ERF contributions to the Illinois Council on Continuing Medical Education in 1976.

### **ICCME Appointments**

Reappointed as ISMS representatives to the ICCME Board of Directors were: Drs. Dean Bordeax, J. Ernest Breed, Edward Cannady, Robert Fox, Boyd McCracken, Mather Pfeiffenberger and George Shropshear. Sheldon Waldstein, M.D., was appointed as a replacement for Willard DeYoung, M.D.

### **Recommendations for AMA Appointment**

The Board will request AMA to reappoint Alfred Faber, M.D., Glenview, for a full term on the AMA's Legislative Council. Dr. Faber, whose term expires in January, was appointed to the council last month to fill an unexpired term. The Board also will resubmit the name of Willard Scrivner, M.D., for appointment to the AMPAC Board of Directors.

### **Printing of IMJ**

Neely Printing Co., Inc., Chicago, will continue printing the Illinois Medical Journal next year, with an option for the following year contingent upon a guarantee of lower pricing.

### **Constitution & Bylaws**

The 1975 House of Delegates will be asked to amend the bylaws by eliminating the provisional membership classification for non-citizens; clarifying various sections dealing with dues payment dates; providing for the temporary absence of the chairman of the Board and for filling a vacancy in that office; naming the immediate past president of ISMS as chairman of the Advisory Committee to the Woman's Auxiliary, and establishing more specific procedures for ethical relations cases. The Board also will seek an amendment that would allow a former member of the society to be reinstated without re-application if all back dues are paid.

### **Directory of Position Statements**

The Policy Committee will compile a directory of position statements on current topics as approved from time to time by the Board of Trustees and the House of Delegates.

### **Membership**

The Board: (1) Approved utilization of the ISMS field service representative in assisting county societies with their recruitment programs; (2) Encour-

aged county societies to involve auxiliary Chapters in recruitment efforts; (3) Directed ISMS to update its membership brochure; and (4) Directed ISMS to provide county societies with the names of newly licensed physicians along with the ISMS "Membership Handbook", as recruiting tools.

### **Public Service Announcements**

The Council on Public Relations will, if feasible, prepare a series of brief public service announcements for use in metropolitan areas where the competition for air time prohibits broadcasting the longer "Dr. SIMS" recordings.

### **Reimbursement for Psychiatric Services**

The Board directed legal counsel to explore possible challenges to arbitrary cut-off of reimbursement for psychiatric treatment under Medicare-Medicaid. The Council on Mental Health and Addiction suggested that the appeal mechanism of the HASP system should cover psychiatric disorders as well as medical illnesses.

### **Revision of Mental Health Code**

Concerned that precipitous action may be taken by the state commission appointed to revise the Illinois Mental Health Code, the Council on Mental Health and Addiction appealed to the Board of Trustees for authority to speak directly to the commission on behalf of ISMS in response to particular proposals if the timetable does not provide leeway for usual review procedures. The Board authorized this direct communication after appropriate consultation with the Executive Committee. The commission will be urged to allow the medical profession to review the proposed code revisions before they are introduced in the legislature. The Board endorsed certain basic platform statements developed by the Mental Health Council to represent an initial position of ISMS on revision of the Mental Health Code.

### **Permit Doctors**

ISMS will call a meeting of representatives of the Illinois Department of Mental Health and Developmental Disabilities, the Illinois Mental Health Association and other interested groups, to build upon recommendations already made, and to study the entire problem of the hospital permit doctor. Additional possible solutions may be developed.

### **Drivers License Information**

The Board approved in principle the placing of organ donor information on Illinois drivers' licenses.

### **Health Care in Penal Institutions**

ISMS will review proposed legislation which would appropriate funds to purchase health insurance for prison inmates and, if acceptable, urge passage of this bill in the next General Assembly. The Board also authorized the Council on Social and Medical Services to establish an ad hoc sub-committee on prison medicine to meet with physicians employed by the Illinois Department of Corrections, penal reform groups, and the medical services administrator of the department.

### **Emergency Medical Services**

ISMS will be a catalyst for establishing a committee representing organizations concerned with emergency health care to serve in an advisory capacity to the Director of the Illinois Department of Public Health. The committee would review and comment on activities of the EMS Division. The Board also authorized the Council on Social and Medical Services to explore the feasibility of

presenting an ISMS award to individuals and organizations within Illinois who make significant contributions to emergency health care. The Board advised the council to consult with appropriate component medical societies about candidates for the awards.

### **Consumer Professional Awards**

The Board encouraged county medical societies to participate actively with local consumer groups wishing to develop patient informational materials, including physician directories. The Board said appropriate guidelines should be established for such publications. Listing of physician fees should be discouraged as this information has little value in determining physician competency.

### **Fee Differentials**

The Board rejected a proposal that it develop a policy position supporting fee differentials between specialists and non-specialists.

### **MEDICHEK Procedures**

Additional time has been granted the Relative Value Study Committee for developing relative values for MEDICHEK procedures. The committee reported that it is preparing a recommendation for structuring an Illinois RVS rather than attacking the problem piecemeal.

### **Fee Profiles From Medicare**

The Council on Economics and Peer Review will develop a form for use by members wishing to obtain individual fee profile data from Medicare carriers. The form will be submitted to the Board for approval and made available to ISMS members.

### **Surgi-Centers vs. Blue Cross**

The Council on Governmental Affairs was directed to develop legislation that would prevent insurance carriers from classifying hospitals and ambulatory surgical care facilities in the same category for reimbursement. Present Blue Cross policy limits surgicenter payments to cost plus 5% (the hospital formula) even though surgicenter costs are considerably less than those of hospitals.

### **Manual of Professional Standards**

The Board approved use of the Manual of Professional Standards (Cleveland Study) as a base-line document for patterns of care in Illinois. It was pointed out that this manual has already been approved by the Illinois Foundation for Medical Care and will be sent to specialty societies and medical schools for review and comment.

### **Doctor of the Week**

The ISMS Doctor of the Week program, which calls for physicians to spend a weeks in Springfield during the Legislative session working on behalf of ISMS bills, will be expanded to eight weeks during the 1975 Session. The program was initiated experimentally this year.

### **State Legislation**

ISMS will act to sustain the Governor's amendatory veto of SB 1676, which improves the liability portion of the bill in the Emergency Medical Services Act.

The Board directed the Council on Mental Health & Addiction to recommend to the Council on Governmental Affairs the position to be taken regarding the Governor's veto message on HB 2710. HB 2710 requires the Department of Mental Health to obtain approval of the General Assembly before closing or discontinuing the use of any mental health facility under its jurisdiction.

The Board will consult with the Council on Affiliate Societies and Sangamon County Medical Society about providing expert medical witnesses for testifying at legislative hearings. The Board also agreed to provide assistance to State Representative Peter Peters in his work with the Rape Study Committee and explore the feasibility of developing legislation to protect doctors delegating medical acts to non-licensed personnel.

### **National Legislation**

The Board commended staff for its efforts in attempting to defeat or amend HR 16204, the National Health Planning Bill which is currently before the Congress.

Authorization was given to the Executive Committee to continue to monitor the developments regarding this legislation and to urge AMA to act aggressively to defeat or amend this legislation, whichever course is feasible.

ISMS will urge AMA to concurrently begin drafting suitable substitute legislation to combine the CHP, RMP and Hill Burton programs in a manner to preserve Health Care Planning as a state function and to maintain state control over federal funds entering the states.

The Executive Committee also was authorized to monitor continuing developments regarding National Health Insurance and advising AMA as follows: opposition to permitting only catastrophic coverage, financed by direct taxation, to be enacted without voluntary coverage for employed persons as called for under the administration's National Health Insurance Plan; modifications of Medicredit to meet the requirements for catastrophic coverage and/or coverage for lower income persons; priority for the right to negotiate fees on the usual, customary and reasonable basis; use of foundations for medical care for peer reviewing physicians bills; use of general revenues in preference to payroll deductions as the preferred taxing method.

### **Continuing Medical Education**

The Council on Education and Manpower was authorized to request the AMA to provide ISMS with organizational accreditation for continuing medical education activities.

### **School Physicals**

ISMS will establish a Task Force to study the practicality of the Illinois School Code requirements mandating physical examinations for children entering kindergarten, first, fifth and ninth grades. The task force will also develop a position statement on the use of para-medical personnel as to what, if any, role they should play in the school health exams.

### **Laboratory Services**

The Board endorsed the following position regarding proficiency testing of laboratory-type services in private physicians' offices:

1. That membership be informed of various programs available for conduct of proficiency testing in laboratory procedures.
2. That every physician be encouraged to participate voluntarily in such testing as would apply to his own practice.
3. That mandatory proficiency testing infringes on the practice of medicine.

The Board also authorized dissemination of the AMA Judicial Council opinions regarding itemization of services on patients bills, especially those related to laboratory services. The Medical Legal Council advised the board that legislation to require such itemization would be considered unnecessary.

## Professional Liability

The Board directed the Public Relations Council to consider the feasibility of a public information program regarding increasing professional liability insurance costs, with assistance from the Medical Legal Council. In a related action, the Board directed legal counsel to draft a statement on personal immunity that can be distributed to peer review committees cooperating with the ISMS professional liability insurance program. An Insurance Committee recommendation that a part-time physician be employed to assist in this program was referred to the Finance Committee. Because of the heavy workload of the Insurance Committee, the Board agreed to increase its size. □

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## EKG of the Month

(Continued from page 484)

Answers: 1. A, C, D 2. A

Lead I of the rhythm strip shows pacemaker artifacts that are clearly not capturing the ventricles. If these pacemaker artifacts are followed vertically, it can be seen in the simultaneously taken leads II and III, that they are followed by a P wave. The pacemaker catheter had fallen into the right atrium and was pacing the atria, later confirmed by fluoroscopy. None of these P waves or the patient's own P waves conducts to the ventricles. Thus he has complete AV block. It can also be seen that the pacemaker artifacts are occasionally sensing the QRS and resetting the pacer on demand. A slow junctional rhythm at a rate of 40 per minute results. The treatment would be repositioning the pacemaker catheter. Agents such as atropine or even isuprel can be used temporarily if the bradycardia causes hypotension and symptoms. This patient was reasonably comfortable at rest. The case is a little unusual in that catheter placement problems tend to occur early in the course after pacemaker implantation. □

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## Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.*

**CAIRO:** FP/CARD/PUL/INT. wanted. Southern Ill. town of 6,500. Several office locations available. Modern community hospital, excellent opportunity for practice, education, public and private schools, Jr. college, and leisure; fishing, hunting, boating. Large cities nearby. Financial arrangements available. Contract Collect: Harvey Pettry, Padco Community Hospital, 2020 Cedar St., Cairo 62914 (618-734-2400) (3)

**CHICAGO:** General Practitioner - full time; centrally located, with no weekends or nights; work on standards for rating disability; evaluation of medical impairment. U.S. Railroad Retirement Board, Attention: J. E. Schwartz, Chief D&H, 844 Rush Street, Chicago 60611. (1)

**CHICAGO:** General practitioners needed for medical center. Complete office facilities. Generous salary. Part-time. Contact: Mrs. E. Tyler or Mrs. S. Hicks, 100 E. Garfield, Chicago 60653 (312-285-3008) (4)

**CHICAGO:** Cermak Medical Center wants a full-time or part-time physician with a good background in Internal Medicine; Cardiology, infectious diseases. A well rounded G.P. Contact: Mr. T. Ebie, Cermak Medical Center, 10 E. Cermak Rd., Chicago 60616 (312-225-2750) (4)

**CHICAGO:** Openings for Emergency Medical Physicians in emergency medical group serving two fine Chicago hospitals. Competitive financial compensation. Contact: Dr. M. Segal, 650 W. Wrightwood Ave., Chicago 60614 (312-327-0777) (4)

**CREVE COEUR:** M.D. URGENTLY NEEDED as an associate in a very active practice in the Peoria area. hospitals. Present M.D. wishes to retire soon and is Family or General Practice within six miles of three hospitals. Present M.D. wishes to retire soon and is concerned with his patients. Financial arrangements and over-all needs negotiable. Only those seriously interested in private practice call collect 309-699-8022 or 309-699-5525 or write William Long, M.D., Creve Coeur, Ill, 60601. (2)

**GENEVA:** GP's or Internists - Outstanding area with unlimited practice opportunities needs you to grow with us. Ideal location for family living in the heartland of the Midwest. Geneva offers the charm of "new England" background - and all only 35 miles from the cultural and medical education advantages of Chicago. Contact: Peter G. Gilbert, M.D. c/o Community Hospital, Geneva 60134 (312-232-0711). (1)

**HAVANA:** Primary physicians needed. A central Illinois Community noted as a fishing and hunting paradise. 50 bed, fully accredited hospital with 25 room clinic adjacent. Guaranteed income for solo, duo or group practice serving an area population of 15,000. Contact: J. M. Dosher, Administrator, Mason District Hospital, 520 E. Franklin, Havana 62644 (309-543-4431) (3)

**JOLIET:** Pediatric psychiatrist to serve as consultant for the John F. Kennedy Diagnostic Clinic. Services include examination and evaluation of children ages 3 to 21; consultation with special education staff and teachers; consultant to classes for behavioral disorders. Contact: Mrs. S. Maxwell, Kennedy Diagnostic Clinic, 420 N. Raynor, Joliet 60435 (815-727-6431 x34) (3)

**KEITHSBURG:** Population 950—we need a doctor badly. We don't have a fancy office. A need of a doctor in three directors. 80 bed hospital=18 miles south in Aledo. Ambulance Service. Rock Island 45 miles away. Resort area on the Mississippi River. Good People . . . Contact: M. L. Stevens, Box 165, Keithsburg 61442 (309-374-2250) (3)

**KEOKUK.** Expanding Clinic with new offices in progressive general hospital offers exceptional opportunity to G.P.'s Internists/Cardiologists, General Surgeon willing to do some G.P. Guaranteed salary, no investment. Group membership one year or less. Surgeon, G.P., OB/Gyn, Pediatrician. Ideal environment. Community 16,000; service area 50,000. Contact: Fred Shrimpton, Administrator, St. Joseph Hospital, Keokuk, Iowa 52632, 319-524-2710. (12)

**MCHENRY:** Immediate opening for Internists, Pediatrician, General Surgeon and Thoracic Surgeon. Outstanding opportunity to join multi-specialty group in mid-west resort area near Chicago. Salary with incentive from day one; fringe benefits and unusually good income potential. Group building directly connected to 143 bed community hospital. Contact: E. F. Wilt, Jr., M.D., McHenry Medical Group, 1110 N. Green St., McHenry 60050 (815-385-1050) (4)

**MORRIS:** Associate wanted - internist, GP, surgeon; growing general practice near Chicago - population 9,000, lovely clean city. Large new office newly equipped. Hospital close. Attractive financially. Keep all you earn. Share office overhead only. Contact: Dr. V. L. Hicks, Bedford Plaza Center, Morris 60450 (815-942-4067). (1)

**NASHVILLE:** Board certified or eligible surgeon - must be willing to do general practice - 3,000-14,000 - 72 bed JCAH hospital - 50 miles east of St. Louis - excellent schools and churchs - outstanding area to live - assistance available - Contact: T. K. Janssen, 603 South Grand Ave., Nashville 62263 (618-327-8236) (1)

**ODIN:** Population 1,300. New medical facilities being installed. Two shelter care homes and small towns nearby without facilities. Hospitals: Centralia twelve miles and Salem five miles, approximately sixty five miles east of St. Louis medical facilities. Recreational facilities nearby. CONTACT: Rolland Devor, Jr., P.O. Box 215, Odin 62870 (618-775-8499) (3)

**PINCKNEYVILLE:** Population 3500—serves an area of 20,000. Medical group partnership of four physicians seeking fifth member. Complete office facilities—2 blocks from fully accredited hospital. Salary one year —then partnership. Good recreational facilities near St. Louis. Contact: C. E. Cawvey, M.D., 206 North Main St., Pinckneyville 62274 (618-357-2131) (4)

**PITTSFIELD:** Need family practitioners and surgeons interested in locating in rural community area. Population 4100; area 18,000. Excellent opportunity for someone wanting to practice in a rural community. Located between Jacksonville and Quincy, on Highway 54 and 36. Contact Dr. T. C. Bunting, Illini

Community Hospital, Pittsfield 62363. AC 217-285-2141 or 217-285-2113. (12)

**ROLLING MEADOWS:** Population 20,000. Five physicians at present. 25 miles from Chicago. Loan available to start practice. One mile from 450 bed Northwest Community Hospital. Good office facilities for one or more Family Practitioners, Internists, Pediatricians. Nearby College. Contact: Keith G. Wurtz, M.D., 1430 N. Arlington Hts., Arlington Hts., 60004 (312-255-3313) (1)

**SPRINGFIELD:** Emergency Room Physician, Join 4 permanent staff physicians at a progressive 580 bed general hospital in Central Illinois. Attractive salary and benefits. Enjoy the relaxed atmosphere in this 92,000 population city. Practice medicine without the worries of office employees and accounting. Contact Arthur Lindsay, M.D. Memorial Medical Center, 1st and Miller Streets, Springfield, Illinois 62705. 217-528-2041. (12)

**WOODSTOCK:** General Practitioner or General Surgeon to join busy two man practice in Northwestern Illinois town of 15,000. New 130 bed general hospital with open staff. Large new office with 15 examining rooms, x-ray and lab facilities. Salary open, many fringe benefits, commensurable with training and experience. Contact: Dr. H. A. Stahlecker, 666 W. Jackson, Woodstock 60098 (815-338-2248 or 338-4666) (4)

## LOYOLA UNIVERSITY-HINES VA HOSPITAL BOARD REVIEW COURSE IN INTERNAL MEDICINE

JANUARY 7—MAY 20, 1975

Every Tuesday night from January 7, 1975 through May 20, 1975, from 6:30 p.m. to 9:30 p.m., a preparatory course will be given for the American Board of Internal Medicine at Loyola-Hines Medical Center. The course will be sponsored by the L. U. Stritch School of Medicine and Hines VA Hospital. There will be 20 sessions given by highly qualified authorities in their respective fields.

|                   |                  |                |                    |
|-------------------|------------------|----------------|--------------------|
| January 7, 1975   | RHEUMATOLOGY     | March 18, 1975 | GASTROENTEROLOGY   |
| January 14, 1975  | IMMUNOLOGY       | March 25, 1975 | PULMONARY          |
| January 21, 1975  | CARDIOLOGY       | April 1, 1975  | PULMONARY          |
| January 28, 1975  | CARDIOLOGY       | April 8, 1975  | RENAL              |
| February 4, 1975  | CARDIOLOGY       | April 15, 1975 | RENAL              |
| February 11, 1975 | HEMATOLOGY       | April 22, 1975 | ONCOLOGY           |
| February 18, 1975 | HEMATOLOGY       | April 29, 1975 | NEUROLOGY          |
| February 25, 1975 | ENDOCRINOLOGY    | May 6, 1975    | NEUROLOGY          |
| March 4, 1975     | ENDOCRINOLOGY    | May 13, 1975   | INFECTIOUS DISEASE |
| March 11, 1975    | GASTROENTEROLOGY | May 20, 1975   | INFECTIOUS DISEASE |

The fee for the course will be \$150.00 (Residents \$35.00) payable in advance. Please make all checks payable to: Loyola University Stritch School of Medicine #1000-24-R

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Send checks and inquiries to: John G. Demakis, M.D.; Assistant Chief of Medical Services; Hines VA Hospital; Rm. 1492; Hines, Ill. 60141

# Obituaries

**••Bolbla, Julius H.**, Flossmoor, died August 24 at the age of 59. He graduated from the Medical College of Georgia in 1940. Dr. Bolbla was Chairman of the Department of Anesthesiology at Ingalls Memorial Hospital in Harvey.

**•Cesafsky, Robert F.**, Oakbrook, died August 30 at the age of 46. He graduated from Loyola University in 1953. Dr. Cesafsky was Vice-President of the Douglas Park Branch of the Chicago Medical Society.

**•Conley, Henry**, Park Ridge, died August 15 at the age of 81. He graduated from the Rush Medical College in 1924. Dr. Conley had served as Director of their Spastic Paralysis Research Foundation.

**•Fouser, Ralph**, Miami, has passed away at the age of 83. Dr. Fouser graduated from Rush Medical College in 1930.

**•Heald, John**, Rockford, died Sept. 1, at the age of 67. He graduated from the University of Nebraska in 1933. Dr. Heald was a past secretary-treasurer of the Winnebago County Medical Society.

**•Mercer, Ray**, Quincy, died August 5. He graduated from the Washington University Medical School in 1906. Dr. Mercer was an eye, ear, nose and throat specialist. He was also an Army surgeon during two wars.

**•Meyer, Herman F.**, Skokie, died August 21, at the age of 74. He graduated from Rush Medical in 1928. Dr. Meyer was an associate and attending physician at Childrens Memorial and Skokie Valley Community Hospitals. He also served on the board of directors of the Infant Welfare Society of Chicago.

**•Ream, Walter**, Peru, died August 24 at the age of 85. Dr. Ream graduated from the University of Illinois in 1943.

**•Stein, Oscar**, Chicago, died August 25 at the age of 80. Dr. Stein graduated from Wein, Austria in 1924.

**•Wheeler, Norman**, Lake Bluff, died August 18 at the age of 63. He graduated from the Georgia Medical College in 1950. Dr. Wheeler was a Medical Director in Clinical Research at Abbott Labs.

**•Williams, Alfred**, Latham, died Sept. 16 at the age of 61. He graduated from the University of Tennessee in 1936.

**•Zimmerman, Nathan**, Chicago, died Sept. 1, at the age of 57. Dr. Zimmerman graduated from the University of Illinois, Chicago in 1941.

<sup>a</sup>Indicates ISMS member

<sup>••</sup>Indicates ISMS member and member of the Fifty Year Club

## STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION (Act of August 12, 1970: Section 3685. Title 39. United States Code)

1. Title of publication: IMJ Illinois Medical Journal
2. Date of filing: September 25, 1974.
3. Frequency of issue: Monthly.

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6. Names and addresses of publisher, editor, and managing editor: Publisher: Illinois State Medical Society, 360 North Michigan Ave., Chicago, Illinois 60691. Editor: T. R. Van Dellen, M.D., 360 North Michigan Avenue, Chicago, Illinois 60601. Managing editor: Richard Ott, 360 North Michigan Avenue, Chicago, Illinois 60601.

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9. For Optional Completion by Publishers Mailing at the Regular Rates (Section 132.121, Postal Service Manual) 39 U. S. C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4339 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates."

In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the reduced postage rates presently authorized by 39 U. S. C. 3626.  
(Signature and title of editor, publisher, business manager, or owner) Richard A. Ott (Managing Editor).

10. For completion by nonprofit organizations authorized to mail at special rates (Section 132.122, Postal Manual). The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes have not changed during preceding 12 months.

### 11. Extent and Nature of circulation.

|   | Average no. copies<br>each issue during<br>preceding 12 months | Actual number<br>of copies of<br>single issue published<br>nearest to filing date |
|---|--|---|
| A. Total no. copies printed<br>(Net press Run)                                | 13,310   | 13,400  |
| B. Paid circulation   |  |   |
| 1. Sales through dealers and<br>carriers, street vendors and<br>counter sales | 200  | 200   |
| 2. Mail subscriptions   | 11,661   | 12,044  |
| C. Total paid circulation   | 11,861   | 12,244  |
| D. Free distribution by mail,<br>carrier or other means                       |  |   |
| 1. Samples, complimentary,<br>and other free copies                           | 976  | 601   |
| 2. Copies distributed to<br>news agents, but not sold                         | None   | None  |
| E. Total distribution (Sum of<br>C and D)                                     | 12,837   | 12,845  |
| F. Office use, left-over,<br>unaccounted, spoiled after<br>printing           | 473  | 555   |
| G. TOTAL (Sum of E & F—<br>should equal net press run<br>shown in A)          | 13,310   | 13,400  |

I certify that the statements made by me above are correct and complete. (Signature of editor, publisher, business manager, or owner)

Richard A. Ott, Managing Editor

# BLUE SHIELD REPORT

FOR *Illinois Physicians*



## Mailing of Medical Assistants' Handbook Planned for January

Production of the 1975 edition of Blue Shield's Medical Assistants' Handbook, prepared by the Professional Relations Department, has been virtually completed and mailing of the Handbook is planned for early in January. Single copies will be sent to physicians' office in Illinois in our white 9½ x 12½ in. Blue Cross-Blue Shield envelopes. *Please watch for this mailing piece.* It is being sent under our third-class postal rate and is likely to arrive with other publications you routinely receive.

The new Handbook consists of 70 pages and cover. Its title is printed in black and our corporate Blue Shield symbol in blue is prominently displayed on the cover. (A reduced facsimile of the cover is shown below).

The format is 8½ x 11-in.; binding is permanent, with the wire-staple method used in most publications. A white durable offset paper was selected in

its manufacture to provide longer usage under frequent handling. The text sections are printed in black. Blue and red are also used to accent section titles and special illustrations.

The basic purpose of publishing the Handbook is to instruct medical assistants in the completion of Blue Shield claim forms and familiarize them with the principal certificates and contracts held by our membership groups. Considerable additional information, however on such subjects as basis of payment, benefit allowances, special coverages and special groups enhances its value and use as an administrative reference manual.

The contents under 11 section titles begins with a history of Blue Shield in Illinois, development and function of the Professional Relations Department, our Blue Shield membership codes, a discussion of basic coverage and standard exclusions, Medicare supplemental coverage and waiting periods.

A 23-page section on Completing Claims includes examples of how to complete data in the Physician's Service Reports for faster claim payments when submitting claims for surgery, surgical assistance, fracture care, medical care, consultation, anesthesia, diagnostic X-ray, radiation therapy, psychiatric care. The section concludes with information on mailing your claim and the Reciprocity program.

Sections follow on:

- Basis of Payment—including discussions of our Usual and Customary programs and Indemnity certificates;
- Schedule of Allowances—in which procedures are listed with benefit amounts for Series "H", "I", "R" and "T" certificates;
- Special Coverage and Features—including Workmen's Compensation, Coordination of Benefits, Coordinated Home Care, Major Medical Care and Comprehensive Major Medical;
- Special Groups—listing our large local and national accounts.

A Directory of Blue Shield Plans, with the name and address of 71 Blue Shield Plans in the United States and Puerto Rico, completes the Handbook.

## MEDICAL ASSISTANTS' HANDBOOK



Blue Shield  
Plan of Illinois Medical Service

# ASK BLUE SHIELD

## ... ABOUT MEDICARE

### LIMITATION ON LIABILITY OF BENEFICIARY AND PHYSICIAN—(Part III)

Part III of the summary of the provisions of Section 1879 of the Medicare Act, entitled "Limitation on Liability of Beneficiary and Physician," concludes the series of articles that began in October, 1974 issue of "Ask Blue Shield About Medicare." The articles were developed from information contained in the instructions on implementing the regulations on the new section of the Act to Medicare carriers from the Social Security Administration, after the regulations became effective in November, 1973.

Part I in October issue included: (1) aspects of the section of the Act that determine whether liability of the beneficiary (or that of the physician or supplier) may be waived in Part B denied claims when assignment is accepted for services or items furnished after October 30, 1972. Examples of services and items not considered reasonable or necessary under Medicare definitions of coverage were given when Waiver would not be an issue.

Part II in November issue summarized notification of claims denied by the Part B carrier and the procedures of Review and Hearing.

The summary that follows explains when payment of a claim may be made under the Waiver of Liability provision, the indemnification process of payment and the conditions that determine when a denied claim may be reviewed retroactively when the Waiver issue is involved:

Where an assumption can be made by the carrier that neither beneficiary nor physician or supplier had knowledge of non-coverage, liability can be waived without statements from either party. Following are some examples:

(1) The service is for a type of treatment that can only be rendered by a physician, but the carrier had not previously denied the coverage of the treatment. (2) The item or service is ordinarily covered but a question is raised whether it is reasonable or necessary in the treatment of the particular diagnosis. Neither the physician or supplier nor medical community has been advised that the item or service is not covered for that diagnosis.

In the first example liability of both parties would be waived; in the second case the determination of the carrier's medical consultant or Bureau of Health Insurance office is required.

#### Indemnification

If a fee or payment has been collected from a beneficiary whose liability was waived, the Medicare program will reimburse the beneficiary, less the amount applicable toward the Part B deductible and coinsurance. The amount paid the beneficiary will be collected by the carrier as an overpayment from the supplier or physician through the usual refund procedure of overpayment, including set-off from future benefits payable if necessary.

In all review and hearing determinations where the beneficiary is found non-liable, a statement is

included which explains this principle. One to the beneficiary would be as follows:

"The Medicare Act provides that, when an individual receives services that are not covered by the program because they are not medically reasonable and necessary, *and such individual did not know and could not reasonably be expected to know that the services were not covered*, the individual is not liable for payment of such services. Since the physician did know or could be expected to know the services were not covered, Medicare cannot make payment to him. If the physician should collect payment for these services from you, Medicare will reimburse you except for any deductible and coinsurance amounts that would apply. Please notify this office or your local Social Security office if you have paid the physician. Any amount paid by you will be collected from the physician by Medicare."

#### Procedures Apply to Retroactive Period

Instructions to the Part B carrier were that the implementation of the regulations began upon receipt of the interim procedures (November, 1973) and would apply to all current claims and claims pending for informal review and hearing.

They may also be retroactive in the following manner:

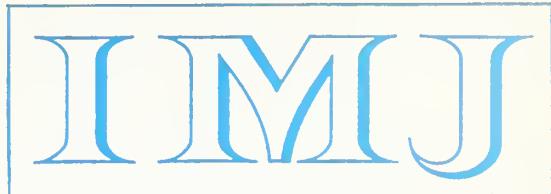
**Hearing cases:** Carriers may review all hearing decisions made on assignment of benefit cases involving services rendered after October 30, 1972, in which the hearing officer denied claims for reasons that the services or items were not reasonable or necessary. The hearing officer can review the record of the case to determine if payment can be made under the new section of the Medicare law.

If it cannot be determined that both the beneficiary and physician or other provider are entitled to waiver of liability, a hearing will be allowed for both parties to present their cases. When liability of both parties can be waived, a revised determination will be made.

The carrier determines whether the physician or other provider has collected payment from the beneficiary, and if so, the beneficiary is reimbursed by the program. Letters of explanation to beneficiaries and other parties will provide complete explanations for these subsequent actions.

Carriers will not attempt to locate closed reviews nor initial determinations where denials were made for items and services not reasonable and necessary. However, if such cases are examined again as the result of an inquiry or other circumstance, the prior determination may be reopened and a decision made on the waiver of liability issue.

If a beneficiary, physician or other provider files a late request for review or hearing, based on a determination made prior to the implementation of the waiver provision, good cause for late filing of the request must be found.



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DECEMBER, 1974

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Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

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## **new Catapres®** (clonidine hydrochloride)

Tablets of 0.1 mg and 0.2 mg

**Indication:** The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

**Warnings:** Tolerance may develop in some patients necessitating a reevaluation of therapy.

**Usage in Pregnancy:** In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

**Usage in Children:** No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

**Precautions:** When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres, in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

**Adverse Reactions:** The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlor-thalidone and papaverine hydrochloride.

Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

**Overdosage:** Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres (clonidine hydrochloride) overdosage.

**How Supplied:** Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.  
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**Reference:** 1. Onesti, G. et al.: Pharmacodynamic effects of a new antihypertensive drug, Catapres (ST-155). Circulation 39:219, 1969.

## Crippled Children Clinics Listed for January

Twenty-nine clinics for Illinois' physically handicapped children have been scheduled for January by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 22 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

|         |    |   |
|---------|----|---|
| January | 2  | Lake County Cardiac, Victory Memorial Hosp., Waukegan |
| January | 7  | E. St. Louis, Christian Welfare Hospital              |
| January | 8  | Champaign-Urbana, McKinley Hospital                   |
| January | 8  | Hinsdale, Hinsdale Sanitarium                         |
| January | 9  | Sterling, Sterling Community Hospital                 |
| January | 9  | Cairo, Public Health Department                       |
| January | 9  | Ellington, St. Anthony Memorial Hospital              |
| January | 9  | Springfield, St. John's Hospital                      |
| January | 9  | Macomb, McDonough District Hospital                   |
| January | 10 | Chicago Heights Cardiac, St. James Hospital           |
| January | 13 | Peoria Cardiac, St. Francis Children's Hospital       |
| January | 14 | Mt. Vernon, Good Samaritan Hospital                   |
| January | 14 | Belleville, St. Elizabeth's Hospital                  |
| January | 14 | Peoria, St. Francis Children's Hospital               |
| January | 15 | Springfield Pediatric-Neurology, Diocesan Center      |
| January | 15 | Joliet, St. Joseph's Hospital                         |
| January | 15 | Evergreen Park, Little Company of Mary Hospital       |
| January | 16 | Rockford, Rockford Memorial Hospital                  |
| January | 16 | Elmhurst Cardiac, Memorial Hospital of DuPage County  |
| January | 21 | E. St. Louis, Christian Welfare Hospital              |
| January | 21 | Rock Island, Moline Public Hospital                   |
| January | 21 | Quincy, Blessing Hospital                             |
| January | 21 | Decatur, Decatur Memorial Hospital                    |
| January | 22 | Chicago Heights, St. James Hospital                   |
| January | 22 | Elgin, Sherman Hospital                               |
| January | 24 | Chicago Heights Cardiac, St. James Hospital           |
| January | 27 | Peoria Cardiac, St. Francis Children's Hospital       |
| January | 28 | Peoria, St. Francis Children's Hospital               |
| January | 29 | Centralia, St. Mary's Hospital                        |

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

## **AS AMENDED AND ADOPTED BY THE HOUSE OF DELEGATES**

### **ILLINOIS STATE MEDICAL SOCIETY**

**SPECIAL SESSION – HOUSE OF DELEGATES – November 9-10, 1974**

#### **REPORT OF SPECIAL REFERENCE COMMITTEE #1**

Mr. Speaker and Members of the House of Delegates:

This Special Meeting of the House of Delegates was called to re-evaluate its previous actions at the Special Meeting of the House of Delegates called on February 24, 1974, and at the Annual Meeting, April, 1974, and to reassess its position on the Professional Standards issue.

The Committee considered all of the evidence presented and interpreted the trend of the testimony offered to support these principles in a general way:

1. That peer review is a desirable function of local medical organizations.
2. That the means by which peer review is conducted and financed may vary in multiple aspects from one locality to another.
3. That the major role of the ISMS with regard to peer review should be in the area of support for the local reviewing groups to whatever extent requested.
4. That many aspects of PL 92-603 and its interpreted rules and regulations are considered contrary to the ideals of optimal peer review. Particular exception is taken to rigidly designated PSRO areas and the unbending attitude of the Secretary of the Department of HEW to reasonable requests for change. Attempts at amendment, and/or repeal should be continued.
5. Vigorous efforts should be made to communicate the position of ISMS to the general public and our legislators.

The Committee then considered each of the eight resolutions submitted and concluded that they could be summarized under 4 major headings:

1. Local option to apply for PSRO designation.
2. State Peer Review Support Center.
3. Permission to apply for federal funds.
4. Further use of Special Assessment Funds.

The eight resolutions before the House each had merit for consideration. However, the Committee feels that the following substitute resolution conveys the intent of the resolutions as supported by the testimony.

RESOLVED, that ISMS authorize those component societies or organizations approved by component societies which desire PSRO designation to apply for such designation, and be it further

RESOLVED, that ISMS or an organization approved by ISMS create a peer review service center outside the purview of the federal PSRO system and, not accepting direct federal funding, to provide—at no cost to ISMS—whatever technical assistance is requested by such local medical organizations, and be it further

RESOLVED, that any peer review service center created must have its board limited to physicians licensed to practice medicine in all its branches, and be it further

RESOLVED, that component societies or organizations sponsored by component societies may apply for federal funds, and be it further

RESOLVED, that those component societies which choose not to seek PSRO designation be provided with an Illinois peer review organization—under the auspices of ISMS or its designated arm and out of the purview of the federal PSRO program—at the option of the majority of the component society members of the organization, and be it finally

RESOLVED, that special assessment funds not committed or spent should be used primarily for education and implementation of efforts to repeal, amend or improve Public Law 92-603 and the development of an Illinois peer review organization.

Mr. Speaker, I move the adoption of this substitute resolution.

Mr. Speaker, this concludes our report. I wish to thank the Committee for the thoroughness and the fairness of their deliberations and decisions.

C. J. Jannings, M.D., *Chairman*  
C. Larkin Flanagan, M.D.  
Morris T. Friedell, M.D.  
John W. Ovitz, Jr., M.D.  
Clifton L. Reeder, M.D.  
James W. Sutherland, M.D.

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### ***Omission***

In the annual Reference Issue of the IMJ, the following information was omitted from the list of County Society Officers:

| COUNTY  | PRESIDENT  | SECRETARY   |
|---|--|---|
| COOK<br>Members: 7,330-Dist. No. 3<br>Robt. J. Lindley<br>Exec. Adm.<br>310 S. Michigan Ave.<br>Chicago 60604 | Howard C. Burkhead<br>2650 Ridge, Evanston 60201 | Henrietta Herbolsheimer<br>5228 S. Hyde Park Blvd.<br>Chicago 60637 |

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states, somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor; delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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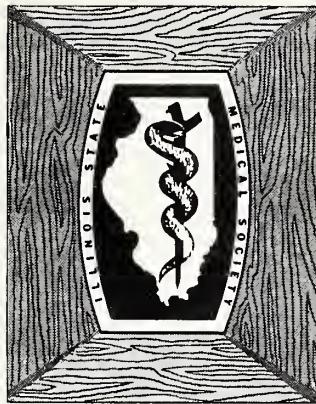
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## Transthoracic Needle Biopsy

BY MIGUEL A. OVIDO, M.D., P. MANALO, M.D., AND  
WILLARD A. FRY, M.D./EVANSTON

The evaluation of pulmonary lesions suspicious for tumor demands a fast, simple, and accurate method for diagnosis in order to indicate proper therapy.

The techniques of sputum cytology, bronchoscopy, bronchial brushing, and diagnostic thoracotomy are all useful in the diagnosis of resectable pulmonary lesions. Mediastinoscopy and/or mediastinotomy are considered staging procedures at our institution.

However, there remains a small group of patients with focal lesions who are still undiagnosed and in whom diagnosis is imperative. Such patients are candidates for transthoracic needle biopsy.<sup>1</sup>



Oviedo



Fry

MIGUEL A. OVIDO, M.D., formerly of Evanston, now resides in Argentina. Dr. Oviedo served his internship and residency at Evanston Hospital. He was an American Cancer Society Training Fellow at the time of writing.

WILLARD A. FRY, M.D., Evanston, maintains a practice in general and thoracic surgery. He is senior attending surgeon at Evanston Hospital and is Assistant Professor at Northwestern University Medical School. Dr. Fry is the immediate past president of the American College of Chest Physicians in Illinois. He is active in the American Cancer Society, Chicago Lung Association and the Chicago Institute of Medicine.

P. MANALO, M.D., is from the Department of Pathology at Evanstan Hospital.

Nordenstrom<sup>2</sup> described and popularized a technique of aspiration needle biopsy of pulmonary nodules using small bore needles and image intensification. His group has diagnostic accuracy of 86% in a large series of transthoracic aspiration needle biopsies. Their incidence of pneumothorax, usually small, is 20%.<sup>2,3</sup>

Large biopsy needles such as the Vim-Silverman or True-Cut give what we consider a rather high complication rate of pneumothorax, hemothorax, and/or pulmonary hemorrhage when applied in the diagnosis of small focal lesions.<sup>4-7,8,9</sup>

Our indications for transthoracic needle biopsy are as follows:

1. Sputum studies are negative.
2. Bronchoscopy and/or bronchial brushing are not diagnostic.
3. Operation is not indicated because of age, poor general medical condition, clinical evidence of metastatic disease, or the need to have diagnosis first before undertaking thoracotomy.

### Method

Routine PA and lateral chest films localize the lesions. We generally accept only patients who are not candidates for thoracotomy. The patient is premedicated with a narcotic and is positioned on the X-ray table so that by fluoroscopy the nodule can be localized. Once the area in the chest wall is selected, the overlying skin is cleansed with Betadine and local anesthesia is procured with 1% Lidocaine down to the pleura. With fluoroscopic assistance a No. 22 spinal needle with stilet is inserted and advanced into the mass, (see Fig. 1) the patient need not be

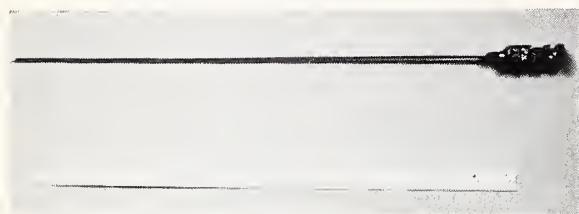


Fig. 1. No. 22 Spinal Needle.



Fig. 2. Poorly differentiated adenocarcinoma.



Fig. 3. Tomogram showing a well circumscribed nodule in the left mid lung field (Patient No. 1).

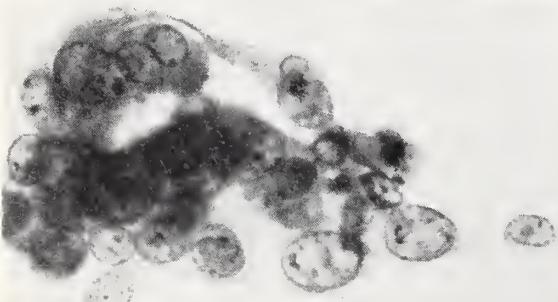


Fig. 4. Poorly differentiated carcinoma.

rotated, because lateral movement of the needle, once it has engaged the lesion, produces definite movement of the mass fluoroscopically.

The needle, once its tip is positioned in the nodule, is rotated to promote cellular detachment. Hand aspiration is performed with a glass syringe containing a small amount of saline. The needle and syringe are removed with slight negative pressure in the plunger.

The specimen is smeared on glass slides, fixed in ether-alcohol, and stained by the Papanicolaou technique. If the specimen permits, a cell block may be prepared and stained with hematoxylin and eosin. The cytology slides can be ready for examination within several hours, thus allowing the physician a very fast diagnosis (see Fig. 2). The specimens are quite scanty, but the material is concentrated and direct.

A chest X-ray is taken immediately after the biopsy to exclude a pneumothorax.

#### Case Reports

*Patient 1.* A 52-year-old white female, four years post left radical mastectomy for Stage 1 adenocarcinoma of the breast, developed right sided chest pain. Radiograph of the chest showed nodules in the apex of the right lung and in the left mid-lung field (Fig. 3). Physical examination was negative except for a well healed left mastectomy scar. Bronchoscopy and bronchial brushing were non-diagnostic. Transthoracic needle biopsy was done, and the smears were positive for adenocarcinoma consistent with metastatic carcinoma of the breast. Accurate diagnosis permitted appropriate therapy for metastatic breast disease.

*Patient 2.* A 65-year-old white male entered the hospital for elective inguinal herniorrhaphy. Physical examination revealed bilateral inguinal hernias and tenderness over the lumbosacral spine.

The chest X-ray showed a 4 x 5 cm irregular density in the right upper lobe and a 3 x 2 cm density in the right lower lobe. Spine X-ray showed an osteoblastic lesion involving the body of the second lumbar vertebra.

Flexible fiberoptic bronchoscopy with bronchial brushing was negative. A transthoracic needle biopsy showed a poorly differentiated carcinoma (Fig. 4). After the needle aspiration the patient coughed up 50 cc of blood and the chest X-ray showed a moderate pneumothorax which was successfully treated with a tube thoracostomy. Radiotherapy to the lung and lumbar spine produced effective palliation.

#### Results

Ten patients were studied of which diagnosis was obtained in nine. Malignancy was present in

eight patients (four bronchogenic carcinomas, four metastatic carcinomas from breast, colon, and pleura). Two patients were reported as negative for carcinoma in our aspirations, and they remain unchanged one and three years later, and we therefore assume that our negative tumor diagnosis was correct.

Ironically, our one false negative patient subsequently had a positive sputum cytology for carcinoma. This institution has reported<sup>10</sup> a diagnostic accuracy of 76% in bronchial brushing in the past. Three of our patients had a negative bronchial brushing and a positive transthoracic needle aspiration for carcinoma.

Three of the 10 patients developed a pneumothorax following transthoracic needle biopsy, but only one required tube thoracostomy. One of them also had an episode of mild transient hemoptysis.

In this series there has been no seeding of the needle tract by tumor. The occasional report<sup>11-13</sup> of such happening in the literature causes us to restrict this procedure to people who are not candidates for open operation, but still need a correct diagnosis for proper therapy.

The patients were referred to us after standard diagnostic procedures failed to make a correct diagnosis. We think that the teamwork of thoracic surgeon, radiologist, and pathologist makes this procedure accurate and worthwhile. As transthoracic needle biopsy gains the confidence of clinicians, its indications may expand. Dahlgren and Lind<sup>14</sup> have shown that in a series of 125 patients, 93% were diagnosed by aspiration biopsy and 64% by sputum cytology.

### Summary

A series of 10 patients with nodular pulmonary lesions is presented. They underwent transthoracic needle aspiration biopsy with a diagnostic accuracy of 90%. There was no mortality or seeding of the needle tract by tumor. Only one patient developed a pneumothorax requiring tube thoracostomy. ▀

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## Chicken Bone in Gallbladder

In a case presented, a 62-year-old white woman was admitted with signs and symptoms of acute gastroenteritis and acute cholecystitis. She was treated conservatively for acute cholecystitis and underwent a definitive procedure for cholecystectomy three months later and did well postoperatively.

Two successive cholecystographic studies failed to reveal the cause of acute cholecystitis except that the gallbladder had been nonfunctioning. There were no perforations in the stomach, duodenum, or colon, but a perforation was found in the gallbladder. A chicken bone and tremendous fibrosis, adhesions, and evidence of recent inflammatory reaction were noted during the procedure. This particular case is rather unusual and very interesting but what puzzles the author is the process of mechanism in the lodgement of the chicken bone to the gallbladder.

Did the chicken bone penetrate through the colon, stomach, or duodenum to the gallbladder? (Nazario R. Capati: Foreign Body in the Gallbladder. *Wisconsin Med. Jl.* Feb. 1974, pgs. S20-S21).

# *Objective Arterial Venous Examination in Peripheral Vascular Disease*

BY JAMES S. T. YAO, M.D., Ph.D., AND JOHN J. BERGAN, M.D./CHICAGO

Although clinical diagnosis of occlusive arterial disease is rarely difficult, there is a need for methods which confirm the diagnosis and provide quantitative information regarding collateral blood flow. In an attempt to achieve these objectives, the Doppler ultrasound technique has been used to evaluate a large number of patients with occlusive peripheral arterial disease. The method is simple, painless, without risk, and gives useful quantitative data. Additionally, it has been found to be useful in studying individual arteries, thus making the method more precise than oscillometry and plethysmography.

Evaluation of the patient with venous insufficiency is difficult because of the inability to palpate venous pulses in the periphery. Physical findings have been proven to be insensitive in detection of venous thrombosis. The ultrasound technique has emerged as the first non-invasive method which measures venous hemodynamics and allows detection of even minor abnormalities.

This report presents an Illinois experience with arterial and venous examinations using the Doppler ultrasound flow detection method. Such examinations are now routine in the Blood Flow Laboratory at the Wesley Pavilion in the Northwestern University Medical Center.

## **Instrumentation**

Three types of transcutaneous ultrasound instruments utilizing the Doppler principle are currently available. There are two portable non-directional ultrasound instruments which use 10MHz\* or 5 MHz\*\* as the transmission fre-

*Supported in part by grants in aid from the Chicago Heart Association and the Northwestern University Vascular Research Fund.*

JAMES S.T. YAO, M.D., Ph.D., Chicago, is Assistant Professor of Surgery of Northwestern University Medical School and Director, Blood Flow Laboratory at Northwestern University Medical Center. JOHN J. BERGAN, M.D., Chicago, is Moerstadt Professor of Surgery and Chief, Transplantation Division, Northwestern University Medical School.

quency. The latter is pocket size and is ideal for bed size use. The third instrument is a directional Doppler flow velocity meter which utilizes a transmission frequency of 10 MHz and provides analog for written records. This is a sophisticated research tool which shows mean velocity, direction of blood flow and flow velocity patterns for recording on a strip chart for a permanent record.

In essence, these instruments use the Doppler effect to detect flow velocity by a frequency shift directly proportional to velocity of moving particles in the blood. An ultrasound beam of 5 or 10 megacycles/second emitting from a ceramic crystal excited by an electric oscillator is coupled to the skin with a gel and then passes through the underlying blood vessel. The back-scattered and reflected sound is detected by another crystal adjacent to the transmitting crystal. Ultrasound reflected from red cells in the blood vessel is shifted by an amount proportional to the flow velocity of the red cells. This back-scattered sound is mixed with the transmitted frequency to produce a signal within audible ranges. A high velocity of blood movement causes a higher pitched sound than does a low velocity movement.

An operating frequency of 5 MHz provides the deep penetration and comparatively broad focus especially suited to deep blood vessels; e.g., iliac vein or vena cava. An operating frequency of 10 MHz permits a sharper focus with shallow penetration and is ideal for blood velocity detection in arteries and veins in the extremities. The frequency shift is proportionally higher for a given particle velocity and the sound produced falls into the middle of the audible frequency range when the 10 MHz signal is used.

The output of this instrument is used to drive a loudspeaker or headphones. A graphic record may be made by incorporating a standard electrocardiograph into the system and an analog output proportional to the flow velocity produced

\*Parks Electronics Laboratory, Beaverton, Oregon.

\*\*Parke-Davis Company, Detroit, Michigan.

using the zero-crossing (frequency-voltage) technique.

For detection of blood flow direction, a phase-shift network is introduced prior to flow detection, permitting identification and separation of positive and negative Doppler shifts. The theoretical considerations of this technique have been reported in detail by McLeod.<sup>1</sup>

### Examination Technique

When the Parks' instruments were used, the flow probe was placed at an angle of 45° to the artery; with the Parke-Davis instrument, the probe is held perpendicular to the artery. A water soluble gel\*\*\* is used to conduct signals between the skin and probe. To obtain a written record (directional Doppler), the probe is first placed in a non-vascular area over the skin. A zero-flow line is recorded by turning the input level of the forward flow channel to the point where small deflections occur. A similar maneuver is performed with the reverse flow channel. The probe is then placed over an artery or vein. Constant wave forms can be obtained if the maximum intensity of audible signals is determined and the level maintained during recording.

#### Arterial Examination

**A. Pulse Examination:** An arterial sound is characterized by its fluctuation in rhythm with cardiac cycles. For diseases affecting the lower limbs, Doppler ultrasound examination is usually conducted at the site of the common femoral, posterior tibial and dorsalis pedis arteries. In the upper limbs, it is carried out at the subclavian, axillary, brachial, radial, ulnar, and all digital arteries. The course of the major arteries can be traced along the limb from the trunk to the extremity of the digit. If thoracic outlet syndrome is suspected, arterial flow examination is conducted with the arm placed in appropriate symptom-producing positions.

**B. Systolic Pressure Examination:** Audible signals are obtained by using the flow probe as a stethoscope, over the posterior tibial or dorsalis pedis arteries. A blood pressure cuff is applied around the ankle above the malleolus (Fig. 1), ankle systolic pressures are recorded at the pressure at which flow signals return during deflation of the cuff. Segmental limb pressures can be recorded by placing the cuff around the calf or the thigh.

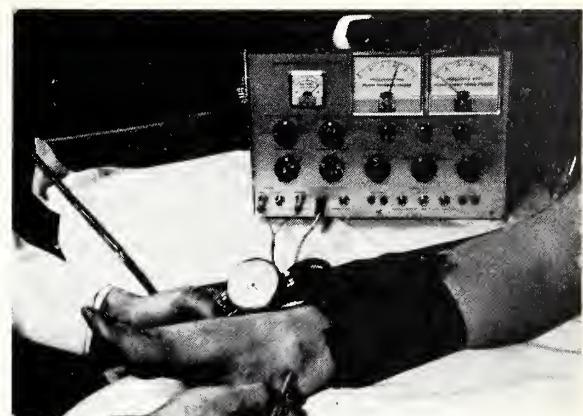


Figure 1. Flow detection and measurement of ankle systolic pressure by the Doppler ultrasound method.

#### Venous Examination

The large veins are identified by their position adjacent to the corresponding major artery. With the leg externally rotated, and the flow probe placed over the common femoral vein just below the inguinal ligament, venous sound can be recognized by its cyclic nature with respiration rather than the cardiac cycle. Breath-holding, a Müller maneuver and a Valsalva maneuver are performed while the probe is held at a position giving maximal sound intensity. The examiner then compresses the thigh and calf and dorsiflexes the foot. These maneuvers produce a distinct, but transient, new sound superimposed upon the background signals over the common femoral vein if venous occlusion is absent. The same examination is then repeated over the popliteal vein, best examined with the patient in a prone position. The patency of the posterior tibial vein is evaluated by compressing the foot.

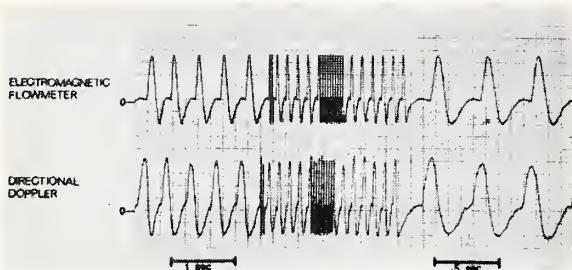
To detect valve incompetency in patients with varicosities, flow reversal (negative flow) is seen when pressure is released after manual compression of the thigh. Incompetency of the sapheno-femoral valve can be verified by placement of the probe over the long saphenous vein. The patient is asked to cough and a roaring sound can be heard. Incompetent perforating veins can also be identified by placing the probe over suspicious areas and then compressing the calf manually. A rush of blood from deep to superficial veins can be heard if perforator valve incompetence is present.

### Results

#### Occlusive Arterial Disease

A total of 350 patients with occlusive peri-

\*\*\*Aquasonic 100, Parker Laboratories, Irvington, New Jersey 07111.



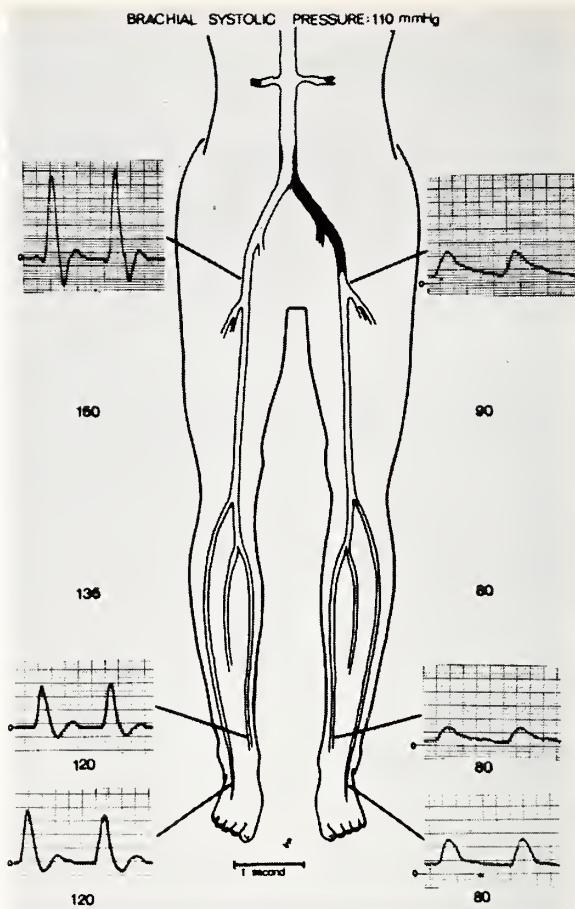
**Figure 2.** The phasic flow patterns recorded from the common femoral artery of a dog with a square-wave electromagnetic flowmeter (upper tracing) and with directional Doppler flowmeter (lower tracing). The flow velocity patterns are identical.

peripheral arterial disease documented by angiography were evaluated in the Wesley Blood Flow Laboratory.

When the probe was used in the manner of a stethoscope, the sound obtained over arteries correlated with its changes in velocity during each cardiac cycle. The normal arterial sounds consisted of first, second and third sounds, with the pitch rising abruptly to a high peak during systole. In patients with occlusive or stenotic lesions affecting the major arteries and in whom pedal pulses were not palpable, abnormal flow signals could usually be obtained over the posterior tibial or dorsalis pedis arteries. These abnormal sounds resulted from collateral flow and were of low pitch. The second and third sounds were absent. When flow signals were detected immediately below a stenotic segment where high velocity flow was present, a single high pitched sound was heard. In the presence of a palpable thrill indicating turbulent flow, the sound was totally irregular, mixed with high and low pitched sounds.

On written records, the flow velocity pattern of a normal artery was triphasic. The major deflection represented forward flow during systole; the second, smaller deflection was caused by reverse flow of a lower frequency during diastole; the third signal represented the return of forward flow. The flow pattern recorded by the directional Doppler was identical with that of an electromagnetic flowmeter (Fig. 2).

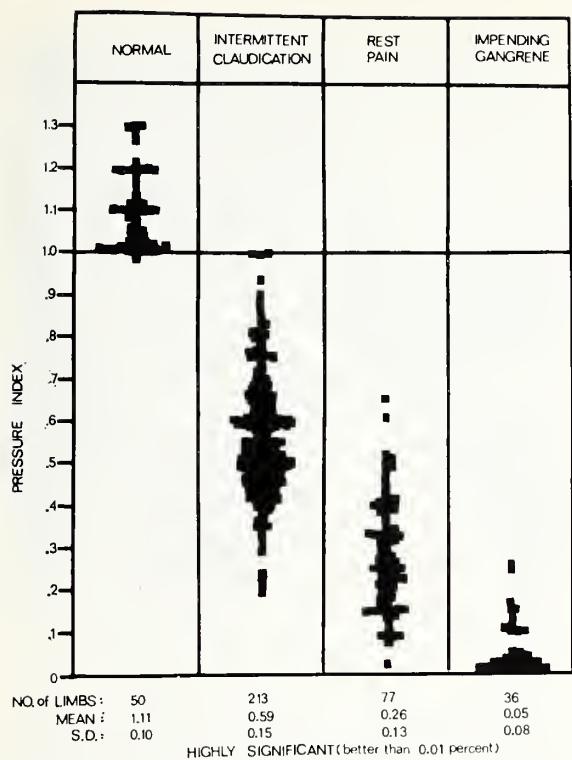
In patients with arterial occlusions or stenosis in whom flow was recorded distal to the occlusion, the flow patterns resulting from collateral flow were monophasic, characterized by a slow acceleration during systole and delayed deceleration, low systolic peak velocity and absence of distinct second and third deflections (Fig. 3). The flow velocity pattern, when obtained immediately below a stenotic lesion with high velocity flow was manifested by a rapid rise and



**Figure 3.** Example of changes in flow velocity patterns and systolic pressure of the lower limb in a patient with iliac artery occlusion. In the normal side (right), flow pattern is triphasic when recorded in the common femoral, posterior tibial and dorsalis pedis arteries. Flow pattern distal to the occlusion (left) is characteristic with absence of negative flow accompanied by slow systolic flow acceleration. A significant decrease in thigh, calf and ankle systolic pressure is also noted.

fall of systolic deflection. The flow patterns obtained where there was a palpable thrill were always irregular. In advanced atherosclerotic disease, where multiple occlusions were present, the pulsatile nature of the flow when recorded from the posterior tibial or dorsalis pedis arteries was almost abolished.

In normal individuals, the ankle pressure measured in a supine position is usually equal to or higher than that in the upper extremity. A pressure index (ankle pressure/brachial pressure) was obtained by comparing the systolic pressure in the lower limb with that in the upper limb. In normal subjects, the pressure index in all instances was greater than 1.0, but in patients with angiographic evidence of occlusion, the pressure index was less than 1.0. The pressure index,



**Figure 4.** The ankle systolic pressure index (percentage of brachial systolic pressure) in four groups of patients. The solid horizontal line represents the lower limit of level recorded in limbs without organic arterial disease. (From *Brit. J. Surg.*)

when used to assess the severity of the disease, was found to have a significant correlation with the patient's symptoms (Fig. 4).

#### Venous Disease

Fifty patients with thrombotic venous disease were studied. In normal subjects with a patent iliofemoral venous system, the vein signal obtained over the common femoral vein was cyclic in phase with respiration. The sound resembled the noise produced by a wind storm. On written records, a clear respiratory cycle was seen in the Doppler flow velocity records (Fig. 5). On breath-holding, flow ceased, the pressure became steady and no sound was heard. With sudden release of the intrathoracic pressure, there was a rapid fall off of venous pressure in the leg and a very loud, roaring sound was heard.

In patients with total iliofemoral venous occlusion, respiratory waves were not seen. The sound was continuous and rumbling in character. Breath-holding did not stop the flow completely and the pressure did not increase. On release of intrathoracic pressure, there was no change in the flow rate (Fig. 5). Patients with varying degrees of obstruction showed intermediate changes between normal and blocked signals. These were

best evaluated when the normal side was used as a control.

In acute deep vein thrombosis involving the distal veins of the leg, absent or diminished audible signals were detected over the femoral vein when the calf was squeezed by the examiner. In a normal patient, deep venous system, a surge of blood was heard. This is the Augmented Sound first described by Sigel and his colleague.<sup>2</sup> Absence or marked diminution of this signal suggests occlusion between the site of compression and the femoral vein.

All patients considered for corrective surgery for varicose veins were evaluated using the ultrasound technique. When the flow probe was placed over the saphenous-femoral junction, the incompetency of distal valves was detected by noting negative flow (reverse flow) during manual compression of the thigh. This was verified by a sudden audible roar heard during patient coughing when the flow probe was placed along the course of the long saphenous vein with the patient in standing position. In calf veins, valve incompetency was detected by manually compressing and releasing the calf. A rush of blood heard with compression was due to backflow, and with release, due to forward flow. Normally venous flow was heard only after release, when blood rushed into the calf muscles.

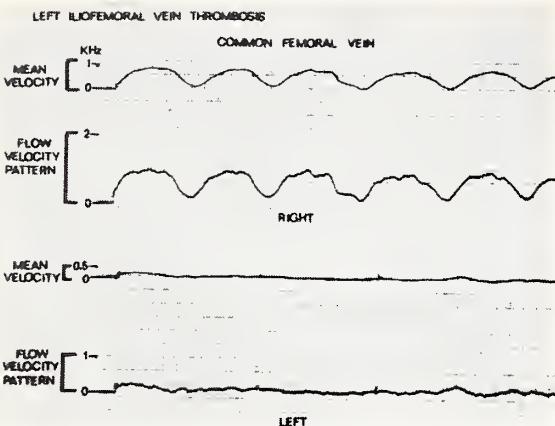
#### Thoracic Outlet Syndromes

Fifteen patients were included in this study. The effect of the scalenus anticus, cervical rib, or costoclavicular margin compressing the artery or vein was studied selectively. The examination was conducted by placing the flow probe over the radial, brachial, axillary and subclavian arteries while the arm or shoulder was held in different positions; e.g., hyperabduction, exaggerated military position or Adson maneuver.

An abrupt change or cease in arterial flow velocity at certain positions indicated the effect of compression by a particular structure. Cessation of axillary or subclavian venous flow when the arm was hyperabducted clearly indicated intermittent compression of the subclavian vein (Fig. 6). Subsequent venograms confirmed ultrasound findings.

#### Discussion

The use of the stethoscope to listen to heart sounds and relate its changes to alteration of cardiac structures is well established, and the recent development of the transcutaneous Doppler ultrasound flow detection method has made it possible to study sound in the peripheral arteries and veins in a similar manner. No special



**Figure 5.** Doppler flow pattern and mean velocity in a patient with left common iliac vein thrombosis. On the normal side (right), respiratory waves are clearly seen. On the thrombosed side (left), flow velocity is continuous and no respiratory modulations are seen. The Valsalva maneuver was absent.

training is required to distinguish the character of the sounds. Once the examiner is familiar with the sounds, he can interpret blood velocity by listening to changes in the pitch. A high pitched sound indicates a high velocity flow and conversely, a low pitched sound suggests a low flow velocity. Absence of first and second sounds together with a low pitch quality to the sound invariably denotes the presence of arterial occlusion proximal to the site of examination. In venous thrombosis, the diagnosis is facilitated by loss of respiratory modulations in the sound.

Currently, the most important single test in physical diagnosis and management of peripheral arterial disease is palpation of the limb pulses. To this can now be added the ultrasound evaluation. The presence of a normal triphasic flow pattern at the femoral artery indicates a patent normal inflow aorto-iliac segment. Abnormalities of this pattern connote lesions of the aorta or iliac arteries. Even in the absence of a palpable pedal pulse in the presence of arterial occlusion, flow through posterior tibialis or dorsalis pedis arteries from collateral channels can be detected by ultrasound. This flow pattern is readily distinguished from the normal flow pattern. Since flow patterns recorded by the Doppler ultrasound method have been shown to be identical to the electromagnetic flowmeter, an inspection of flow during acceleration and deceleration allows an estimation of the severity of the obstruction process.

In animal experiments, Keitzer, et al, have reported change in the oscillatory flow pattern manifested first by elimination of the backflow



**Figure 6.** Brachial venogram performed during hyperabduction showing complete occlusion of the subclavian vein (left) by external compression.

phase (negative flow) when occlusion of an artery approaches 70% of the diameter of the lumen.<sup>3</sup> With occlusion approaching 90%, attenuation of systolic acceleration is observed. By applying these changes in Doppler flow patterns, the degree of ischemia, the presence of inflow tract obstruction can be ascertained.

The significance of recognition of proximal inflow lesions prior to undertaking femoro-popliteal artery reconstruction has been emphasized by several authors. The Doppler ultrasound flow pattern recording at the femoral artery improves selection of patients for reconstructive surgery. For example, since ultrasound flow detection permits detection of pulses obscured by obesity, the presence of normal triphasic flow patterns in the common femoral artery obviates the need for lumbar aortogram when weak femoral pulses are caused by such obesity.

Although indirect determination of arterial pressure by the sphygmomanometer method of Korotkoff is one of the most commonly used measurements in clinical medicine, little use has been made of its application to the lower limbs because the method is not applicable in the presence of arterial obstruction. Winsor, using a plethysmograph, first described the value of ankle systolic pressure measurement and suggested the pressure index (Ankle to Brachial Ratio) to differentiate normal patients from those with occlusive arterial disease.<sup>4</sup> Previous investigations have shown that ankle systolic pressure recorded by the Doppler ultrasound method

has proved far more accurate than plethysmography.<sup>5-7</sup> This discrepancy can probably be explained in two ways. First, the Doppler ultrasound method allows selective examination of an artery. Second, changes in tissue turgor such as edema affect circumferential expansion of the limb, thus making plethysmographic pressure recording unreliable.

Experience has shown that in measurement of ankle systolic pressure, pressure index not only aided in confirming the clinical diagnosis but provided an objective basis for determining the severity of the disease process.<sup>6</sup> The more extensive the disease process, the lower the pressure index (Ankle/Brachial Ratio). The group of patients with multiple arterial occlusions demonstrated the greatest gradient between the brachial systolic pressure and the systolic pressure at the ankle. The pressure index was found to have a significant correlation with the patient's symptoms.

Currently, clinical evaluation of venous disease is more difficult than assessment of arteries. Diagnosis is often made on indirect evidence such as swelling, edema or tenderness. These clinical signs, though helpful, are frequently misleading. The results of this study have shown that the Doppler ultrasound flow detection technique is a useful adjuvant method for establishing venous diagnosis. The presence of abnormal flow patterns, the response of venous flow velocity to the Valsalva or Müller maneuver aid in determining patency or degree of occlusion of the iliac, common femoral and popliteal veins. Diagnosis of venous thrombosis distal to the popliteal vein was found to be reliable.

In addition to simplifying the diagnosis of deep vein thrombosis, the Doppler ultrasound method was of particular value in studying vein valve function. Detection of valvular incompetency at the sapheno-femoral junction and accurate location of perforators improved the surgical results in treating varicose veins.

While occlusive arterial lesions in the upper extremities occur much less frequently than in the legs, the wide spectrum of neurological and vascular disorders causing disability of the hand and fingers provide a diagnostic challenge to the clinician. Various thoracic outlet maneuvers are available for the differential diagnosis of ischemic symptoms affecting the hands and fingers. By using the Doppler ultrasound method, not only is an assessment of arterial flow velocity possible, but subclavian vein flow can also be evaluated. Such information cannot be obtained with routine examination of the pulses.

## Summary

A simple, non-invasive technique based on the Doppler principle is now available for arterial and venous examination in patients who present with ischemic symptoms of varying etiology. Audible signals, flow velocity patterns, direction of blood flow and systolic pressure in the limbs are the parameters used to establish the diagnosis. The function of the collateral flow can be accurately ascertained. In diagnosis of deep vein thrombosis, venous insufficiency, or thoracic outlet syndromes the method is of particular value as a screening test prior to angiographic examination. □

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## Coronary Artery Aneurysms

Two patients in which an antemortem diagnosis of coronary arterial aneurysm was made by means of selective coronary cineangiography are presented in this paper. The patients were, respectively a 66-year-old white male and a 49-year-old white male. Each was found to have multiple coronary artery aneurysms. These were the only cases of multiple coronary artery aneurysms demonstrated in the authors' series of over 2,000 selective coronary cineangiograms. The commonest cause of coronary artery aneurysm is arteriosclerosis. Patients might present with symptoms of angina pectoris, myocardial infarction, congestive heart failure, and/or sudden death secondary to rupture of the aneurysm. The authors review the literature on this subject and discuss indications and contraindications for surgery. One of the two patients reported by them underwent aortocoronary saphenous vein graft implantation and has had a good postoperative course. (Alberto Benchimol, et al.: Multiple Aneurysms of the Coronary Arteries Demonstration by Selective Coronary Arteriography. *Arizona Medicine* Oct. 1973).

# A Clinical Evaluation of Simple Renal Cysts

BY THOMAS LANYI, M.D., ALAN SKOLNICK, M.D., AND DAVID PRESMAN, M.D./CHICAGO

In view of the apparent markedly increased incidence of simple renal cysts in recent years, this lesion no longer can be considered a rarity. This is most likely due to the more frequent use of intravenous urography as a screening procedure in patients with urological disease as well as those with complaints referable to other organ systems.

Most studies dealing with renal cysts have been primarily concerned with the problem of differential diagnosis from renal tumor. Since intravenous and retrograde urography, as a rule, demonstrate only a space-occupying mass, there has been special emphasis on the diagnostic features of nephrotomography, renal arteriography, and percutaneous aspiration with injection of contrast media. However, relatively little attention has been given to the clinical aspects and symptomatology of renal cysts which might aid in the differential diagnosis and provide a more rational approach to management.

To this end, a retrospective analysis was made of the clinical features of 42 patients discharged from Michael Reese Hospital in the past few years with the diagnosis of renal cyst. In each instance, the initial diagnosis of a space-occupying lesion was apparent on intravenous urography. The final diagnosis was based upon either surgical exploration or what appeared to be unequivocal radiological evidence on nephrotomography or renal arteriography. In those cases which were not explored, there was a minimum follow-up period of two years without any clinical or laboratory evidence of a renal tumor.

The data were reviewed with specific reference to age, sex, indications for intravenous urography, symptomatology, differential diagnosis, and management.

DAVID PRESMAN, M.D., Chicago, is Chairman, Division of Urology at Michael Reese Hospital and is consultant at Cook County Hospital.

At the time of writing, THOMAS LANYI, M.D. and ALAN SKOLNICK, M.D., were Residents in Urology at Michael Reese Hospital.

## *Age and Sex*

The ages of the patients ranged between 20 years and 80 years with the largest percentage comprising the 50 to 70 year age group (90%). There were 34 males and 8 females, a ratio of approximately four to one. The difference in sex incidence may be more apparent than real since males are subjected to intravenous urography very commonly in the course of a work-up for lower urinary tract disease.

## *Indications for Intravenous Urography*

1. Vague backache or flank pain which was thought to be due to upper urinary tract pathology in 8 patients (19%). In several of these patients a renal or ureteral calculus was present but in no instance could the pain be ascribed to the renal cyst.

2. A palpable, asymptomatic flank mass was discovered on two patients during routine physical examination. In both patients, renal arteriography demonstrated a very large lower pale cyst which extended to the iliac crest and in one of these patients there was a tumor of the upper pole separate from the cyst. These findings were confirmed at surgery.

3. A suspected renal mass visualized during radiological studies for other than genitourinary symptoms. These included an abdominal plain film during the course of a transbrachial cerebral arteriogram (1 patient) and gastrointestinal X-rays (3 patients).

4. A history of gross hematuria was found in eight patients (19%). In 7 of these patients, the hematuria was either initial or terminal, whereas total hematuria occurred in only one patient. In each instance, the gross hematuria had ceased by the time cystoscopy was performed so that the precise origin of the bleeding could not be definitely determined. The presumptive cause of the hematuria was diagnosed as either benign prostatic hypertrophy, prostatitis, or hemorrhagic cystitis.

5. Twenty patients (48%) had routine work-

up for complaints referable to the lower urinary tract, most commonly the prostate gland. This comprised the largest group and, in every case, the renal cyst was an incidental finding of no clinical significance.

#### *Symptomatology and Laboratory Findings*

Localized flank pain or tenderness was not present in any of the patients. A cyst was palpable in only two patients in whom the mass extended inferiorly from the lower pole of the kidney. It is of interest that in the remaining patients, the cyst could not be palpated even after radiographic demonstration of its presence.

The hemogram was normal in all instances; polycythemia did not occur. Mild elevation of the blood urea nitrogen and creatinine was found in an occasional elderly patient with obvious evidence of chronic bilateral renal disease. Urinalysis revealed a mild degree of microscopic hematuria in seven patients, all of whom had a previous episode of gross hematuria which was presumably due to other genito-urinary conditions.

#### *Differential Diagnosis and Management*

Regardless of the clinical picture, the diagnosis of a space-occupying mass in a kidney rests between cyst and tumor. Until the recent development of more precise radiological techniques, surgical exploration had been almost routinely performed as a diagnostic procedure. This resulted in many unnecessary operations which, although generally safe, were followed occasionally by morbidity of varying degrees and even a rare mortality.

With the advent of nephrotomography and renal arteriography, it is no longer necessary to resort to surgical exposure in order to determine the nature of every renal mass. The criteria for differentiating renal cyst or tumor by these radiological procedures have been repeatedly documented and are well known. It is to be emphasized, however, that exploration is indicated in any patient in whom the X-ray findings are equivocal or if there is clinical suspicion of a renal tumor.

In this series, a nephrotomogram was performed in 24 patients, 16 of which were interpreted unequivocally as a cyst. In eight patients, there was some doubt so that renal arteriography and/or exploration was carried out except for one patient who refused further investigation. A cyst was demonstrated in each of the above seven instances; the last mentioned patient has

been followed for three years without clinical evidence of a tumor.

A total of 19 patients had a renal arteriogram. A definite diagnosis of cyst was made in all but two patients in whom surgery confirmed the presence of a cyst.

Surgical exploration was performed in eight patients. In one patient, previously described, there was a lower pole cyst and an upper pole tumor, both of which were confirmed at the operation. In the remaining seven patients, surgery was advised because of a history of hematuria of undetermined origin or because of the remote possibility that a tumor could be present at the base of the cyst.

#### **Discussion**

There have been several articles in the urological literature stating that all space-occupying renal masses should be explored because of the occasional occurrence of an avascular tumor simulating a cyst on radiological studies. This point of view is also held by those who postulate that a small tumor may be present at the base of a cyst.

The most prudent approach to this problem would seem to be a careful evaluation of the individual patient based upon both clinical and radiological studies. Surgical exploration is obviously in order when either a nephrotomogram or arteriogram demonstrates any opacity or vascularity in a renal mass. Surgery is also indicated if the radiographic studies are, to any degree, equivocal or inconclusive. In particular, special credence is given to the renal arteriogram which, in our experience, has proven to be the most reliable diagnostic procedure.

If a renal cyst is discovered as an incidental finding during the course of a work-up for other pathology and is unconditionally confirmed by a nephrotomogram or arteriogram, surgery is not recommended.

However, even with a radiological diagnosis of cyst, surgery is advised under the following conditions:

- a. Cystoscopic observation of ipsilateral bloody ureteral reflux.
- b. Persistent microscopic hematuria in the absence of other urinary tract pathology.
- c. Localized flank pain or tenderness.
- d. A history of anorexia, weight loss or gastrointestinal symptoms which cannot be accounted for.
- e. The presence of metastases without a demonstrable primary lesion.

*(Continued on page 563)*

# Boutonnière Deformity

BY GABRIEL E. CHAN, M.D., ALBERT J. ZUSKA, M.D., AND  
THOMAS W. MCNEILL, M.D./CHICAGO

The radiographic findings in Boutonnière deformity of the finger are characteristic, yet the Standard Nomenclature of Athletic Injuries<sup>1</sup> published in 1968 states that radiographic examination of this deformity is negative unless there has been a bony fragment avulsed. Boutonnière deformity is commonly seen in orthopedic practice and commonly discussed in orthopedic literature; however, the radiologist rarely mentions Boutonnière deformity in his diagnosis. Only one reference has been found in the radiology literature that describes the radiographic findings in Boutonnière deformity.<sup>2</sup> The purpose of this paper is to describe the radiographic appearance, pathoanatomy and etiology of Boutonnière deformity for the radiologist.

The Boutonnière deformity of the finger is characterized by flexion of the proximal interphalangeal joint and usually hyperextension of the distal interphalangeal joint. Hyperextension may also be present in the metacarpophalangeal joint.<sup>3-11</sup>

The radiographic appearance is that of a finger or fingers with the above described positional deformity. No other bone or joint changes need be present, and the typical soft tissue changes are not reflected in the X-ray appearance. (See Figs. 1 and 2).

## Anatomy

At first sight, the anatomy of the extensor mechanism of the finger seems very complex. However, when reduced to its functional components the anatomy becomes somewhat less formidable. (Fig. 3).



Chan



McNeill



Zuska

GABRIEL E. CHAN, M.D., is Assistant Professor of Radiology at the University of Illinois Medical Center, Chicago. Dr. Chan is certified by the American Board of Radiology and American Board of Nuclear Medicine.

THOMAS W. MCNEILL, M.D., River Forest, is Assistant Professor of Orthopedic Surgery, Abraham Lincoln School of Medicine and Chief of Orthopedic Surgery at West Side Veterans Administration Hospital, Chicago.

ALBERT J. ZUSKA, M.D., Oak Park, at the time of writing was Chief Resident, Department of Radiology at the University of Illinois Medical Center, Chicago. Dr. Zuska graduated from the University of Illinois College of Medicine and interned at Evanston Hospital.

There are two muscle groups which provide the active extension of the finger joints: the extensor digitorum communis and the intrinsic muscles of the hand (lumbricales and interossei). These two muscle groups exert their pull through a common tendon system which has two main components: the central tendon (which attaches to the middle phalanx) and the paired lateral bands (which attach to the distal phalanx).<sup>4</sup>

Extension of the metacarpophalangeal joint takes place through the action of the long extensor through fibrous attachments to the flexor tendon sheath.<sup>7,12</sup> The attachment of the extensor tendon to the proximal phalanx dorsally does not participate in active extension.<sup>12</sup>

Extension of the proximal interphalangeal joint takes place through the central tendon slip; extension of the digital phalanx is mediated via the lateral bands.<sup>7,8,12</sup> Flexion of the metacarpophalangeal joint is mediated by the interossei when the extensor tendon is relaxed.<sup>4,7</sup>

The lateral bands are maintained in position by attachments to the flexor tendon sheath (Landsmeer's ligaments)<sup>7,12</sup> and dorsally by the triangular ligaments.<sup>9</sup>

## Pathoanatomy

The Boutonnière deformity is a flexion con-



**Figure 1.** Advanced rheumatoid arthritis of the hands with Boutonnière deformities of left middle, ring and little fingers and right index, middle, ring and little fingers.

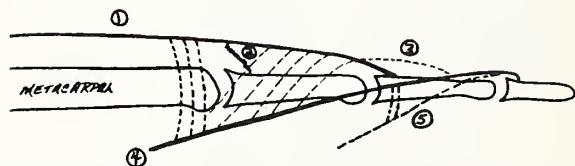
fracture of the proximal interphalangeal joint, usually with hyperextension of the distal interphalangeal joint of the finger. This is caused by loss of attachment of the central slip to the middle phalanx, plus a defect in the dorsal extensor mechanism (tendon or triangular ligament) through which the proximal interphalangeal joint protrudes.<sup>5,6,9,13,14</sup> (Fig. 4).

With the loss of the central slip and triangular ligament, four events take place in the tendon system: (1) Most of the force of the extensor muscles is transmitted to the distal phalanx via the lateral bands; thus, hypertension of the distal phalanx is produced. (2) The force of the sublimus is unopposed; thus, flexion of the proximal interphalangeal joint is produced. (3) The lateral bands shift volarward past the axis of motion of the proximal interphalangeal joint; thus, the lateral bands become flexors and perpetuate the deformity. (4) Landsmeer's ligaments contract and hold the lateral bands in the dislocated position; thus, fixed deformity is eventually produced.<sup>4-7,9</sup>

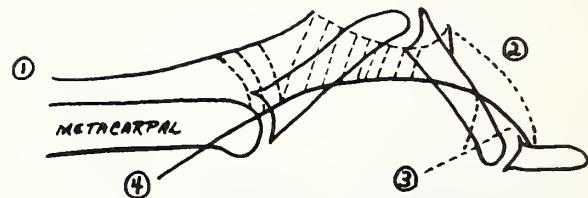
Flexion deformity, without protrusion of the proximal interphalangeal joint through the extensor hood, may be produced by several other causes and may mimic Boutonnière deformity. For instance, a nodule in the flexor tendon may block extension of the proximal interphalangeal joint<sup>15</sup> or a contracture of Landsmeer's ligaments in Dupuytren's contracture<sup>12</sup> may produce flexion of the proximal interphalangeal joint with hyperextension of the distal interphalangeal joint. Adhesions of the volar fibrocartilaginous plate following joint injury also will produce



**Figure 2.** Lateral view of the middle finger showing Boutonnière deformity due to trauma.



**Figure 3.** The normal anatomy of the extensor mechanism of the finger: (1) central slip; (2) loose attachment of central slip to proximal phalanx; (3) triangular ligament; (4) lateral band; (5) Landsmeer's ligaments.



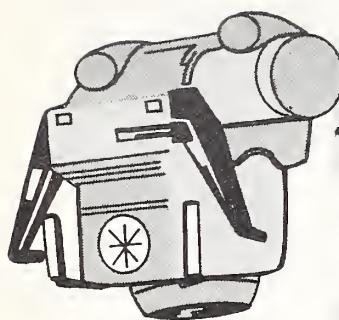
**Figure 4.** Pathoanatomy of Boutonnière deformity: (1) ruptured central slip; (2) elongated triangular ligament; (3) Landsmeer's ligament; (4) volar displacement of lateral bands.

flexion deformity of the proximal interphalangeal joint.

### Etiology

The deformity may be secondary to rheumatoid synovitis,<sup>3,6,14-16</sup> blunt trauma,<sup>5,7-9,13</sup> forced digital flexion,<sup>8,11</sup> burns,<sup>8,9</sup> and laceration across the dorsum of the proximal interphalangeal joint.<sup>9</sup>

(Continued on page 559)



# the viewbox

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLoY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



Figure 1



Figure 3



Figure 2

Three different female patients are presented each of whom had a pelvic mass. A routine infusion IVP was done and tomographic sections were taken of the pelvis. With this technique a diagnosis could be entertained as to what each pelvic mass would be.

(Answers on page 574)

# *Can Essential Hypertension Be Approached Prophylactically?*

BY YOUNG O. CHANG-DAVIDSON, M.D. AND LEO L. DAVIDSON, M.D./GALESBURG

Essential hypertension is a disease which, together with other heart diseases, is the primary cause of death in all life statistics of the world. (It was found as the cause of death in approximately 15% of all deceased who were older than 50 years of age.) Besides these losses of life, other expenses must be considered. The World Health Organization, for instance, recently issued a bulletin according to which patients who suffer from essential hypertension and its consequences require more hospital and health center beds and furthermore, more social assistance than cancer and accident victims combined.

This disease is far more prevalent than previously assumed. For instance, it is approximated that in the USA about 10 million hypertonic live undetected and that about 5 million people, although knowing that they suffer from the disease, do not subject themselves to regular medical treatment. Perhaps the reason for this lies in the fact that this disease can proceed for many years without showing any symptoms and without affecting the well-being of the afflicted while, at a later time, when discomforts do occur, therapy is frequently inadequate and cannot prevent the further progression of the disease.

Recently, active fighting of the disease with antihypertensive means was recommended even for well-feeling hypertonic (the mortality rate is said to have been reduced by up to 50% and considerably fewer complications were observed, such as strokes, progressive heart and kidney diseases, etc.). But still this disease, despite all of these successes, remains to this day a disease which can only be diagnosed relatively late and which, due to its deadly progression, is still the No. 1 problem in medicine.

Hitherto, it was not possible to fight this disease by prophylactic means. In the literature we find hints that the beginning of essential hypertension lies in the age of youth, but no further consequences were drawn from this and no recommendations were made. The reason for this is that at the start of the disease, no symp-

The authors did their research for this article in West Germany, Soviet Union and in the United States. At the time of this paper they were graduate resident physicians at Galesburg State Research Hospital, Galesburg.

tom can be found which is pathognomonic for essential hypertension. Thus, one does not know what to search for and, hence, early cases of the disease remain undetected.

To conduct systematic blood pressure checks of entire population groups in order to detect early cases of essential hypertension (analogous to the roentgenological mass examinations in the case of the prophylaxis of tuberculosis) is technically difficult, would be time consuming, and would be of dubious success.

In the Soviet Union, such a prophylaxis was planned to be tried in a slightly modified form. In the cities, blood pressure measuring centers were planned where everybody could have his blood pressure measured free of charge. In this manner, it was hoped to find early cases of essential hypertension, so that early therapy could be initiated. The idea was dropped though, because it was feared that, besides essential hypertonic, a much larger number of cases caused by the medical attention would occur which then would also require treatment. This would make the prophylactic approach too all-encompassing and its purpose would become illusionary. Therefore, the search for prophylactic measures had to be channeled into a different direction.

Of guiding character in this search were the statements made by Sir G. Pickering who said that the difference between hypertension and normal blood pressure is only "quantitative" and not "qualitative." Practically, this means that in the early stages of hypertension, one merely has to look for very small blood pressure increases, because only they—and they alone—would indicate the presence of the disease or the tendency for it. To this day, no other abnormalities which are characteristic for this blood pressure ailment were found by medical researchers and scientists. The statements quoted above, however, did not make the road toward the prophylactic fight against essential hypertension any easier. The difficulties do not become any smaller if one stops to realize how difficult it frequently is to properly interpret small blood pressure increases, their distinction from the normal, and the psychogenous and other blood pressure reactions. In addition, there is the dependence of blood pressure values upon age, sex, and race, besides the dif-

ferences between the blood pressure values in the right arm and in the left arm. (Especially high blood pressure differences between the left arm and the right arm were found by Paul Uhlenbrück with the oscillograph according to Gesenius and Keller. They were explained by him as caused by vessel spasms.) These are all facts which do not move the goal of a prophylactic approach against essential hypertension any closer.

### Methods and Results

For several decades, methods for a prophylaxis of essential hypertension were sought, aimed in the direction of overcoming all of the blood pressure evaluation and diagnosis difficulties mentioned above. During more than 10,000 blood pressure measurements conducted on carefully selected ill and healthy persons of both sexes and of different ages, we were able to obtain a well founded work hypothesis which makes it possible to conduct usable blood pressure studies and subsequent scientific conclusions.

We proceeded as follows: (all blood pressure measurements were conducted with the apparatus according to Riva-Rocci.)

1. The blood pressure was always first measured at the left arm.

2. The applied pressure was never increased rigorously and to the extreme, but it was gently increased in order to prevent pain due to pressure.

3. The examined persons had to be relaxed in a sitting position.

4. The initially obtained blood pressure values taken at the left arm were taken to represent the present blood pressure value, independent of the values which were obtained during the subsequent measurements in the right arm.

5. When the blood pressure values on the left arm were found to be high and the subsequent measurements on the right arm showed normal or sub-normal values, the value obtained on the left arm was considered to be more important, i.e., the blood pressure was judged to be high in all such cases.

6. The blood pressure on the left is always the decisive denominator, providing it is measured first.

7. If, during the blood pressure measuring, the measurements are at one time first taken at the left arm, while at the next time, they were first taken at the right arm, then the obtained blood pressure values yield no clear picture of the present blood pressure conditions.

8. Normally, the measured blood pressure value is at the left arm generally higher than on the right arm. Exceptions are rare.

9. In the case of youths between 16 and 18 years of age, the systolic blood pressure is up to a level of 135 mm Hg normal. However, if it remains at this level longer than four months without downward fluctuations, then it must be considered to be pathological.

10. The normal diastolic blood pressure in the case of youths between 16 and 18 years of age is normal up to a level of 80 mm Hg. Higher diastolic values probably indicate the presence of latent essential hypertension.

### Case Reports

With the work hypothesis reported above as the basis, we investigated the blood pressure of 223 healthy male youths for a period of three years.

All examined youths were between 16 and 18 years of age. All of them were Caucasians and were employed as machine operators in the aircraft manufacturing industry, working 40 hours per week. Their jobs consisted of punch press operating, welding, and grinding, i.e., jobs which require moderate physical exertion. Their medical examination showed nothing pathological. None of them had any complaints. Their prior medical history and that of their families showed nothing unusual. Heart X-ray, blood, and urine analyses showed no deviations from the normal. The ECG and eye background examination were also normal. Some of these examinations were repeated if this appeared necessary. Normally, the youths were examined in intervals of two weeks. Those youths who initially showed normal blood pressure values were examined in somewhat longer intervals. The blood pressure was measured at every visit, sometimes right at the close of the shift, in order to catch possible work increases.

It must be emphasized that there were difficulties involved in the examinations reported above. All examined youths felt well and healthy and, thus, considered all medical orders superfluous. Therefore, the blood pressure measurements frequently had to be made at the work bench and medical personnel had to watch if medications were taken or not. For instance, we ordered Reserpin® 0.25 mg twice a day in such cases where the systolic blood pressure showed constant values of 135 mm Hg for a period of four months and in such cases where the diastolic blood pressure was above 80 mm Hg for more

than three months.

Although the Reserpin® was given free of charge, we could not be sure if the medication was also taken on weekends and holidays. The youths showed little understanding for these blood pressure studies and were of the opinion that their good health hardly made them a fitting object for these studies. They had no complaints about side effects of the Reserpin.® We ordered Reserpin® up to six weeks after normalization of the blood pressure, because we observed that the increased diastolic pressure values return to normal and remain there only after long Reserpin® treatment.

### Comment

The results of the blood pressure studies were as follows:

1. Of 223 youths, 156 showed from the very start normal systolic and diastolic blood pressure values. Their values remained normal.

2. Of the remaining 67 youths, 43 exhibited constantly increased systolic blood pressure values of 135 mm Hg and 24 youths showed constantly increased diastolic values of 85 and 90 mm Hg.

3. Of the 43 youths with constantly high systolic blood pressure, in 27 cases, the blood pressure spontaneously returned to normal only after three months of observation. In the remaining 16 cases, Reserpin® had to be ordered, since the blood pressure showed no decreasing tendency even after 4 months of observation. In both groups, the blood pressure remained normal.

4. With the 24 youths which showed high diastolic blood pressure values, we could not observe any spontaneous decrease of the diastolic values. Only if we ordered Reserpin® after three months of observation, we could obtain normalization of the blood pressure values in six cases. In the other 15 cases, the diastolic blood pressure remained unchanged. It is very likely that an increased dose of Reserpin® was necessary. The further fate of these 15 youths is unknown to us, because we changed the place of employment.

5. The remaining three youths were inducted into military service, but were soon released. Their discharge diagnosis was: essential hypertension. At the beginning of their reemployment in civilian life, their blood pressure values were 150/85 mm Hg, 160/90 mm Hg, and 170/90 mm Hg. Again, they voiced no complaints.

### Summary

A work hypothesis based on large scale blood pressure studies permitted us to conduct easily

comparable blood pressure studies on youths and we can recommend this method as a prophylactic method for the fight against essential hypertension since it is very likely that it makes it possible to recognize potential victims of hypertension.

Large scale blood pressure measurements on youths are to be recommended as prophylactic measure.

For the successful fight against potential hypertension, these measures are most urgently indicated, because of the 223 examined youths, 40 were very probably afflicted with the potential indications of this disease. ▲

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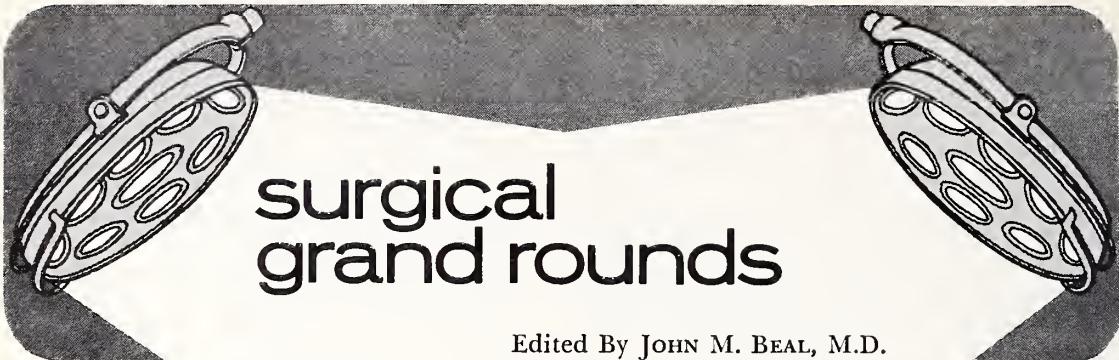
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# surgical grand rounds

Edited By JOHN M. BEAL, M.D.

## Splenectomy

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of September 18, 1973.*

**Dr. Bernard Swartz:** A 52-year-old white man was admitted to the hospital August 26, 1973, for investigation of thrombocytopenia. He gave a history of easy bruising and bleeding which began when he was 13 years old. He reported numerous problems with bleeding during dental procedures and other surgical procedures in the past. In 1958, he was admitted to the Mayo Clinic for a bleeding duodenal ulcer where diagnosis of thrombocytopenia was made. However, he refused splenectomy at that time. Earlier this year, laboratory studies were reported to show a normal prothrombin time, a normal partial thromboplastin time and a normal thrombin time. Earlier, when he was in the hospital for other reasons, a bone marrow aspirate demonstrated a marked increase in the number of megakaryocytes. Peripheral smears showed decreased platelets with bizarre oval forms and cigar-shaped forms. A family history of bleeding disorders was not present. He had other problems, including coronary insufficiency, hypertension, benign prostatic hypertrophy, chronic lung disease and a seizure disorder, which are not pertinent to the present presentation. His medication was phenobarbital.

Physical examination at the time of admission revealed a well developed white man, not in distress. Blood pressure was 148/100 and pulse

was regular and 88. Significant physical findings included numerous petechiae on his skin and numerous bruises over his extremities and on his chest wall. Liver was palpated two finger-breaths below the costal margin with a span of 13 cm, was firm and non-tender. The spleen was not felt and peripheral lymphadenopathy was absent.

Laboratory data on admission: hematocrit 47, white blood cell count 8,000, platelet count 9,000. Prothrombin, thrombin and partial thromboplastin times were within normal limits. Electrolyte levels were within normal limits. Platelet survival studies were obtained and showed that he had splenic entrapment of his platelets. A one week course of prednisone did not increase his platelet count. On September 6, splenectomy was performed. When the spleen was removed, he was given 600 cc. of platelet-rich plasma which had been obtained from his brother earlier in the morning. These were HLa identical platelets. Postoperatively, blood was drawn in the recovery room and revealed a platelet count of 176,000. The first postoperative day, the platelet count was 244,000 and seven days postoperatively, it had increased to 1,369,000. After ten days the platelet count was still 1,094,000.

**Dr. Hector Battifora:** The presence of a large

number of megakaryocytes would indicate that the bone marrow responded in making more platelets. Although some megakaryocytes have a smooth outline indicating that they are not yet producing platelets, most megakaryocytes appeared more mature with pinching of the cytoplasm in the production of platelets. So there is nothing wrong with his capacity to make platelets. Now, the spleen was of normal size but he had a remarkable change on cut surface and all these dilated spaces or lakes of blood which gave a very striking gross appearance. These also could be seen from the capsular aspect. These represent the very large distended sinusoidal spaces, some of them perhaps extravasational, which continued large number of red blood cells. This is reminiscent of a process rarely found in the liver, and even more rare in the spleen, called peliosis which, as far as we know, is not accompanied by any specific clinical manifestation. It is usually an incidental autopsy finding. So, we would be curious to know if the patient has similar changes in the liver, but I don't have a description of the liver at the time of laparotomy. Since most of these cases can be associated with no pathology, it is difficult to ascribe to these vascular changes any significance; but one could speculate in this case that they may have something to do with the trapping and destruction of the platelets.

**Dr. John Beal:** In the surgical treatment of hematologic disease, it is essential that there be close cooperation between the hematologists and the surgeons. Dr. David Green, from the Department of Medicine, will discuss the problems which this patient presented.

**Dr. David Green:** This case is very interesting because of the long-standing (15 year) history of thrombocytopenia. The patient's bleeding problems became progressively worse during the past one year. In view of the long history of bleeding, we wondered if he might have one of the more rare forms of thrombocytopenia, a congenital thrombocytopenia, such as the May-Hegglin anomaly. These disorders have often been mistaken for immune, acquired thrombocytopenias when actually the defect is in platelet production. To exclude this possibility, his platelets were examined by electronmicroscopy and no abnormality in the platelets could be discerned. So, we concluded that he had an immune thrombocytopenia. It was also interesting that this patient had not received steroids despite the fact that he had such a long-standing thrombocytopenia. Therefore, we undertook a trial of steroids.

His platelet count was 8,000 before and 8,000 after a 10 day course of prednisone (40 mg. per day). Prior to operation, we did a platelet survival study using HLa-matched platelets obtained from his son. We initially recovered only about 30% of the platelet radioactivity and by four hours virtually all of the platelets were gone (the half-life was 2 hours). We found that radioactivity over the spleen was high immediately after injection of the platelets and rose to even higher levels by four hours. The spleen to liver ratio was better than 3 to 1 which indicates significant splenic sequestration. Armed with this data, we felt confident that the splenectomy would give some benefit. Postoperatively, the platelet survival was greatly improved. The half-life was now 20 hours. These were the platelets that were infused immediately after the splenic pedicle was ligated. We homogenized an aliquot of the excised spleen and found that 60% of the previously injected radioactivity was still present in the spleen. This clearly demonstrated that the radioactive platelets had indeed been taken up by the spleen.

**Dr. Barry Kahan:** Actually the purpose of this presentation doesn't relate to the commonly presented problem of hypersplenism alone, but just how we can approach patients who require splenectomy or other surgical procedures and have platelet counts in the range of below 10,000. I think the experience of everyone in the group has been that administered platelet transfusions from random donors frequently fail to increase the platelet count; indeed, frequently the counts are even lower than at the start due to consumption of the patient's own platelets. It is rather common knowledge that refractoriness to platelet transfusions occurs almost invariably after 14 units have been given, which is just two occasions of giving six or seven units. Thereafter, one cannot really count on random platelets to afford a good increment and stop an active bleeding problem. So, the discussion of this patient's case became a touch stone for presenting some of the research related to platelet typing and transfusion therapy.

A part of the interest of the members of the Transplantation Unit in platelet typing arose from the recognition that the same factors control immune responses against platelets as those which elicit the rejection of kidney grafts. Therefore, studies of the survival of transfused platelets and the immunity of patients against these cellular particles may increase our understanding of patient responses against the antigenic factors

which cause graft rejection. The usual patient who is considered for this program is one who has had multiple blood or platelet transfusions in the past and has demonstrated that he is refractory to this therapy, that is, his platelet count does not increase when given random platelet transfusions. Such patients may be outside the hospital with platelet counts of 30,000 and not be in jeopardy until he starts bleeding, or requires a surgical operation. A large number of patients are undergoing cancer chemotherapy which induces secondary thrombocytopenia due to bone marrow depression. One cannot provide these patients with matched transfusions if one delays until the patient has started bleeding or requires surgery since HL-A typing and the choice of a compatible donor require days of investigation. We are attempting to identify patients who may be candidates for platelet transfusions early, perform their HL-A typing, and get potential donors assigned in order to be prepared to immediately transfuse the patient when he requires platelets. I've asked Dr. Mittal who directs the Tissue Typing Laboratory in the Department of Surgery to explain the HL-A system and how typing is performed for platelet transfusion.

One other aspect of this case is worthy of mention. The platelets were prepared from the single HL-A identical donor by celltrifuge. The platelet donor was heparinized, blood cells were drawn off from the patient, passed through the celltrifuge, only collecting lymphocytes and platelets, and returning the red cells and the majority of the plasma back to the donor. The platelet packs which were obtained were not the usual 50 cc aliquots, but indeed blood transfusion bags containing 300 cc of platelet rich material. I think the delivery of platelets was more efficient in this form, and therefore recommend the wider application of the celltrifuge for this purpose.

**Dr. Kamal Mittal:** Before we discuss this patient, I would like to briefly discuss the nomenclature and serology of the tissue antigens. All tissue cells are known to carry distinctive surface markers called antigens on their plasma membrane. Among this array of markers are antigens of the leukocyte HL-A system and antigens of the erythrocyte ABO system which control transplantation compatibility in man.

The HL-A system is genetically independent of the red cell systems and is determined by genes at a single pair of autosomal chromosomes. It appears to consist of 2 closely linked loci which are called locus or segregant series 1 and locus or segregant series 2. The allelic antigens which can

be detected at each of the two loci are given in Table 1. A person can have any two antigens of the first series and any two of the second series depending on the paternal and maternal chromosomes one inherits. Thus, excluding the possibility of "crossing-over," there can be only four kinds of offspring in a family, as shown in Table 2. In this family the father has chromosomes (or haplotypes), HL-A1, 8 and W24, W5, while the mother's haplotypes are HL-A3, W5 and W32, W5. Children C1, C2 and C3 show presence of three different combinations, while C4 is identical to C1 for the HL-A antigens but not for the ABO antigens. A fourth possibility would be a combination W24, W5/W32, W5 (or

Table 1  
HUMAN LEUKOCYTE ANTIGEN GROUPS

| Segregant Series 1 | Segregant Series 2 |
|--------------------|--------------------|
| HL-A1              | HL-A5              |
| HL-A2              | HL-A7              |
| HL-A3              | HL-A8              |
| HL-A9              | HL-A12             |
| HL-A10             | HL-A13             |
| HL-A11             | HL-A14             |
| HL-A28             | HL-A17             |
| W23                | HL-A27             |
| W24                | W5                 |
| W25                | W10                |
| W26                | W15                |
| W29                | W16                |
| W30                | W18                |
| W31                | W21                |
| W32                | W22                |

Table 2

|     | ABO | HL-A Phenotype  | HL-A Genotype               |     |
|-----|-----|-----------------|-----------------------------|-----|
| F   | A   | 1, W24; 8, W5   | a<br>1, 8/W24, W5<br>c<br>d | a,b |
| M   | O   | 3, W32; W5, -   | 3, W5/W32, W5               | c,d |
| C1  | O   | 1, W32; 8, W5   | 1, 8/W32, W5                | a,d |
| C2* | A   | 3, W24; W5, -   | W24, W5/3, W5               | b,c |
| C3  | O   | 1, 3; 8, W5     | 1, 8/3, W5                  | a,c |
| C4  | A   | 1, W32; 8, W5   | 1, 8/W32, W5                | a,d |
| C5  | A   | 11, W32; W10, - | Not in Family               |     |

\*Patient

Table 3  
PLATELET TRANSFUSION

|         | ABO | HL-A Phenotype | Cross-Match    |
|---------|-----|----------------|----------------|
| PATIENT | B   | 1, 3; 7, 8     |                |
| SON     | B   | 1, 2; 7, 8     | Neg. IDENTICAL |
| SISTER  | B   | 2, 3; 7, 12    | Neg.           |

b, d). Unfortunately, the patient (C2) has no identical donor available in the family. C5 does not appear to be a biological member of this family.

Each antigen group is defined by several sera reacting almost identically. The most commonly used leukocyte-typing technique is called the "Lymphocyte Microcytotoxic technique." One test requires 0.001 ml of a typing serum and 0.001 ml suspension of 1500 lymphocytes from the person to be typed. More than 600 such tests are performed with the cells from a person. The cells and sera are incubated for 30 minutes at 22°C before addition of 0.005 ml of rabbit C. After additional 60 minutes incubation at 22°C, 0.003 ml of eosin dye is added to stain the dead cells, and 0.008 ml formalin is added to fix the reaction. All reactions are examined by phase contrast microscopy, and data are analysed by a variety of computer programs.

With regard to tissue matching, strong evidence is available which shows that kidney and skin allografts and leukocyte or platelet transfusions between HL-A identical siblings survive

longer and function better than those between HL-A non-identical individuals. Generally, living related individuals make better donors. However, when no such donor is available for a platelet transfusion, we select the best matched individual from a computerized pool of unrelated volunteer donors.

Table 3 shows the results of typing the patient, his son, and his sister. Although very rarely a child has an identical match to a parent, it happened in this case. Cross-match between patient's serum and the son's lymphocytes also was negative. This qualified the son as an ideal donor for this patient. Dr. Green already has discussed the results of the transfusion performed in this case.

I would recommend to you that as soon as a patient is identified as a potential recipient of platelet or granulocyte transfusions, it is advantageous to get the patient and all family members tissue typed immediately to be prepared for this exigency. This could be done when a patient has a platelet count of less than 30,000, or granulocytopenia in the face of unremitting infection. ▲

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# Perinatal Health in Illinois

BY GERALD F. STAUB, M.D./ROCKTON

*Public Law 78-557, signed into law in September of 1973, mandates the development of a statewide plan for perinatal health by the Illinois Department of Public Health. As directed by PL 78-557, the Illinois Committee for Perinatal Health, a committee of IDPH, prepared such a plan. The following article is a description of this plan and an explanation of the effect this plan will have on the practice of obstetrics in Illinois.*

## Nature and Scope of Problem

Perinatology (the discipline devoted to the woman from conception, her fetus and newborn) and Neonatology (the discipline of the newborn through the first month of life) are relatively new disciplines in the health field.

These new areas of interest have become increasingly sophisticated and formalized in the past ten years, as an outgrowth of the need to reduce newborn morbidity and mortality in the United States. Among developed nations of the world, the United States ranks only fourteenth in neonatal survival.

In Illinois hospitals in 1973, there were 26.5 perinatal (stillbirth and neonatal) deaths per 1,000 live births and 11.4 neonatal deaths per 1,000 live births; a total of 1,892 neonatal deaths.

Further, of the approximately 5,100 neonates in Illinois requiring intensive care in 1973, less than half of these infants actually reached or were born in a Center with the capability of giving this type of care. This was due to lack of availability of care centers, lack of funding for catastrophic illness, lack of ready access to centers through consultation, lack of referral patterns, lack of established transport system, and the need for educating public and professionals on the value of neonatal intensive care. It is estimated that 2.5-3% of all newborns require intensive care and another 2-3% require some form of special care (i.e. short term intravenous fluids, exchange transfusions and careful observation by trained personnel).

There are no readily available statistics for perinatal morbidity in Illinois. Many patients in our mental health institutions and cerebral palsy

GERALD F. STAUB, M.D., Rockton, a neonatalogist, is Director, Regional High Risk Newborn Center, Rockford and Assistant Professor, Pediatrics, Rockford School of Medicine. Dr. Staub is Chairman of the Illinois Committee for Perinatal Planning and serves on the Illinois Perinatal Coordinating and Illinois Premature Advisory Committees.

programs are reminders of the morbidity associated with the hazards and problems of newborn adaptation. In terms of cost effectiveness, it has been determined in Illinois that lifetime cost for an institutionalized mentally retarded person is \$250,000\*. Whereas, the cost of the proper expectant management of the woman at high risk, even during a problem pregnancy or the management of her newborn often may be less than \$2,500. In terms of priorities for effort and funding, the average life span of an infant in a neonatal intensive care unit is 72 years as compared to 6 years for a patient in a Coronary Care Unit.

The availability and quality of care, particularly preventive care, for the high risk (medical, social economic, etc.) mother-fetus, new-born in Illinois is reflected in the disparities noted in comparing the data from various areas of the State. There are serious deficiencies in prenatal, preconceptional, and between pregnancy services for women and in follow-up and evaluation services for the early detection of correctable or remedial conditions in high risk newborns in the first 3 years of life.

The realization that the knowledge and technology exists today to reduce perinatal mortality by 50% has led to the development of a Perinatal Plan and Program in Illinois. The resources to effect this reduction as well as that of the more significant problem of perinatal morbidity are present in Illinois, but to date these resources have not been sufficiently organized and coordinated to permit achievement of these goals.

Identification of problems, needs, manpower and facilities available and responsibility of agencies or groups has not been a serious difficulty but the best use of our resources, particularly time, expertise, effort, and funding through planning, establishing priorities and organization has

\*Illinois Department of Mental Health, 1972.

not yet been accomplished.

### The Purpose of Plan Development

*Identify and Characterize the Perinatal Health Service Regions* and subregions of the state with the intention that these regions could serve as suitable models for other fields of health service delivery is the charge. Characterizing a region would include defining of the target population and referral patterns, an inventory of resources, quantifying needs and the ability to evaluate the health service delivery system.

*Provide the Basis for a Statewide Perinatal Health Program*—thus, this program would include the activities of all levels of the perinatal health care system and related professional educational and service institutions. From the Program would come the data base and educational support, funding, consultation, planning and administrative expertise, research and development, and leadership to assist the development of the various regional programs.

*Provision of Guidelines* is planned for regional comprehensive health planning groups to develop perinatal health care plans for their service area based on their determination of population need, long and short term objectives, and the priorities for those objectives.

*Foster development of an atmosphere of optimal perinatal health management among the public, providers and planners.*

### Planning Organization

The planning effort began in April, 1973, after the Illinois Committee for Perinatal Health contracted with the Comprehensive State Health Planning Agency, the Illinois Department of Public Health and the Rockford School of Medicine, University of Illinois, to develop a statewide plan. Impetus and priority were added to the development of the Plan with the enactment in 1973 of Public Act 78-557, an Act relating to the prevention of developmental disabilities. The Act provides for the development of a perinatal plan in order to furnish the guidelines and standards necessary for designing a practical, workable Perinatal Program.

Neither the Act nor the Plan attempt to dictate how the care is to be delivered, but do establish the framework for achieving a goal of optimal care for the perinatal patient. Planning was directed to two major areas; one to provide recommendations to the Illinois Department of Public Health for those facets relating to delivering optimal perinatal health care. This would

include care levels, facilities, staffing, training and manpower needs, transportation, regionalization and funding.

These recommendations also would furnish the guidelines for hospitals and their professional staffs and the several local health planning agencies for perinatal planning in their respective areas.

The Committee, 33 members in all, is composed of obstetricians, pediatricians, family practitioners, nurses, hospital administrators, public health officers, health educators, social scientists, health planners, and public information specialists. The following organizations are among those represented on the Committee:

Illinois State Medical Society  
Illinois Chapter American College of Obstetricians and Gynecologists  
Illinois Chapter—American Academy of Pediatrics  
Illinois Academy of Family Physicians  
Illinois Nurses' Association  
Illinois Hospital Association  
Illinois Department of Public Health  
University of Illinois, College of Medicine  
Southern Illinois University, School of Medicine  
Illinois Association for Maternal and Child Health  
Regional comprehensive health planning agencies  
Chicago Board of Health

### The Planning Process

The Plan was formulated through the activities of seven subcommittees:

#### *Care Levels, Staffing and Facilities*

Developed guidelines for minimum standards of care on three levels: general, intermediate, and intensive. These guidelines are to be used in aiding hospitals themselves to determine and declare their capacity to provide certain perinatal services. This subcommittee reviewed the perinatal service plans of those hospitals desiring to become perinatal medicine intensive care centers.

#### *Regionalization of Perinatal Care*

Developed a basis for distribution of care resources called perinatal health service regions based on size of target group, survey of needs, resources available and development of data base for the problem areas of perinatal health. From this information, this subcommittee determined whether the interested hospitals met the care level criteria. This information is to be considered in the Perinatal Medicine Intensive Care Center selection process by the Comprehensive State Health Planning Agency, the local health planning agencies, and the Illinois Department of Public Health.

### *Transportation and Communication*

In conjunction with the Emergency Medical Services and Newborn Care Programs in the State and from information on the location of proposed perinatal medicine intensive care centers and referral patterns, this subcommittee has developed recommendations regarding vehicles and modes of travel, support, equipment, and personnel and communication linkages between centers, referring hospitals and transport vehicles.

### *Public Attitude and Education*

This subcommittee is responsible for publicizing the planning effort and the nature and implementation of the Perinatal Plan through a Statewide Perinatal Newsletter (for health professionals) and the public media. Emphasis will be on creating public awareness of the benefits of optimal health care to mother-fetus and infant and encouraging them to seek out this care.

### *Primary Prevention*

This subcommittee has developed guidelines for adequate prenatal, obstetrical, postnatal and between pregnancy care within a model regional program. This program includes early identification, management, and follow-up of the high risk female of child-bearing age and her offspring.

The emphasis is on primary prevention and the prevention of certain high risk factors or related complications and provision of maternal health care rather than crisis intervention as the best means of reducing perinatal mortality, morbidity and disabling conditions. Statistical evaluation has been developed to assess the impact of the program on fetal and neonatal survival as well as neonatal morbidity.

### *Professional Education and Training*

From an inventory of current courses and educational opportunities available in Illinois, the needs, description of courses for training of perinatal personnel have been developed at all levels (practicing physicians, fellows, nurses, allied health specialists). These recommendations would be implemented in conjunction with major medical centers (principally medical school associated) with training programs and the State-wide Area Health Education System.

### *Liaison, Legislation and Funding*

Provided the interface with the Comprehensive State Health Planning Agency, the Illinois General Assembly, the Illinois Department of Public Health and all other institutions and parties on

an official basis for this committee. This group has compiled the various subcommittee's reports into the draft of The Plan and made funding determinations and applications.

The writing of the Plan was completed in April, 1974. From the subcommittee reports, data from the Illinois Department of Public Health, research (see bibliography), study of perinatal programs in other states and discussion and development at committee meetings, the first edition was finalized for printing in July, 1974.

### **The Perinatal Health Program**

The Program is the implementation of the Plan through the continuing goal directed activities (planning, care delivery, education, evaluation) and support of many of the components of the perinatal health system and governmental bodies in the state. Participating components would include but would not be limited to: the primary health care system, the community hospitals, the university and community college based education system, the executive and legislative branches of state and local government, the state and local health departments, comprehensive health planning agencies, perinatal medicine (intensive care) centers, and the professional societies for family practitioners, obstetricians, pediatricians, and nurses as well as organizations specifically devoted to perinatal health such as the Illinois Association for Maternal and Child Health.

### *Perinatal Health Program Objectives:*

Through the well-defined activities of each of the components of the Perinatal Health Program, the following objectives can be accomplished:

- Effectively and significantly decrease perinatal morbidity, mortality and developmental disabilities in Illinois.
- Improve availability and quality of prenatal services, prior to conceptual history, obstetrical, postnatal and between pregnancies. Establish primary prevention programs to identify early and reduce the health risk to the high risk female of child-bearing age and her offspring.
- Provision of the appropriate level of care required by each perinatal patient as close to his home as feasible (optimal care).
- Consolidation of local perinatal services and resources wherever feasible and in the best interest of the public.
- Regionalization of specialized health care services, particularly intensive care with

the necessary transportation and communication support.

- Education of the public to the advantages of seeking and using improved perinatal services.
- Training and continuing education for all categories of involved perinatal health professionals particularly at the local level, to provide adequate manpower to meet the need for more quality care to be available and delivered to the public.
- Evaluation of results, planning, and development of the Illinois Perinatal Health Program on a continuing basis.
- Promote an attitude that recognizes the woman of child-bearing age, the fetus and newborn as deserving high priority for public concern and of appropriate governmental and private funding of health programs.

#### *Major Recommendations:*

In order to achieve the Program objectives, the accomplishment of the following major recommendations from the Plan is felt to be important:

- Five perinatal regions should be established throughout the state.
- Each region should have one or more perinatal medical intensive care centers, each center serving areas with about 16,000 live births.
- Within and between regions, links for education, consultation and referral should be created between the perinatal medicine intensive care centers and all other hospitals with obstetric and newborn services with services to be delivered through multidiscipline perinatal teams from each center.
- A perinatal high risk transportation and communication system would be developed within the Division of Emergency Medical Services and Highway Safety of the Illinois Department of Public Health in cooperation with the perinatal medicine intensive care centers.
- Gaps in adequate insurance coverage for

the health care of mothers, and infants should be closed through legislative modification of the Illinois Insurance Code.

- The Illinois Nursing Practice Act should be amended to recognize the legitimate roles of the perinatal nurse practitioner and the nurse midwife.
- Identification of significant high risk factors in the female of childbearing age, preferably before her conceptual history, should be made utilizing the required 5th and 9th grade history and physical examinations.
- There is a need for all pregnant women to be evaluated during the first trimester. That need should be an objective of all perinatal health education and service programs.
- Funding for patient care and transportation costs within the new perinatal program not covered by non-governmental third party reimbursement should primarily be borne by the State and other governmental agencies.
- There should be annual review of the Perinatal Plan and Program by the Illinois Department of Public Health and its perinatal health advisory committee.
- A committee should be designated by the Illinois Department of Public Health to assist in overseeing the implementation of the Perinatal Plan.
- Basic public health services are a prerequisite for effective perinatal primary prevention, of disease or complications, and therefore should be available to all citizens of the State through organized and adequately staffed and funded local health departments.
- An Educational Coordinator should be employed to work with the perinatal teams to manage the perinatal education program at both the state and regional level.

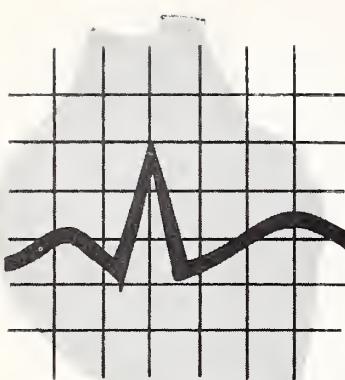
A proposal for carrying out these recommendations will be the subject of a subsequent paper, Part II—The Implementation of the Illinois Perinatal Program. □

## **ISMS New Headquarters**

Effective in 1975, the Illinois State Medical Society office will move to 55 E. Monroe St., Suite 3510, Chicago, 60603. The phone number will remain the same.

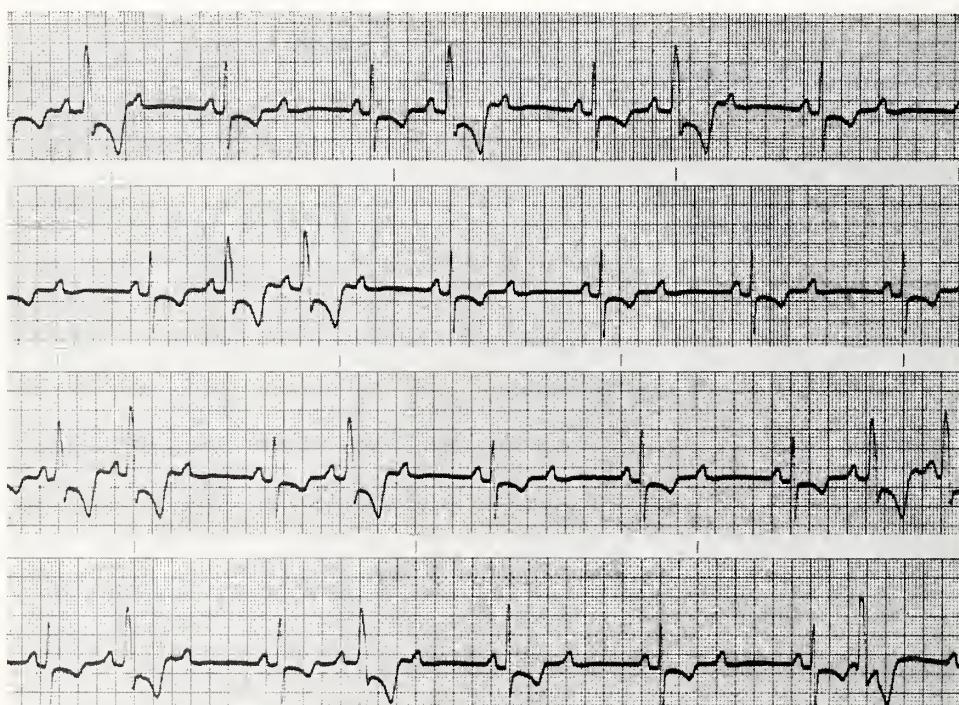
Housed at this new address include the staffs

of the *Illinois Medical Journal*, Illinois Foundation For Medical Care, Illinois Council on Continuing Medical Education, Illinois Psychiatric Society, Illinois Society of Internal Medicine, and Illinois Ophthalmology Association.



## Ekg of the month

JOHN R. TOBIN, M.D., M.S., RIMGAUDAS, NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
JAMES V. TALANO, M.D., SARAH JOHNSON, M.D. and  
ROLF M. GUNNAR, M.D., M.S./Section of Cardiology,  
Loyola University Stritch School of Medicine



A 67-year-old robust man came to the office complaining of palpitations and weakness. The palpitations were further described as heavy beating of the heart which started one month earlier but was occurring more frequently now. He also described feelings of weakness which accompanied the palpitations. His pulse rate was approximately 50 beats per minute and irregular. Blood pressure and the remainder of the physical examination were normal. A long lead I rhythm strip was obtained and is shown. He was taking no medications.

Questions:

**1. The ECG rhythm strip shows:**

- A. First degree AV block.
- B. Second degree AV block
- C. Rate related complete left bundle branch block.
- D. Occasional premature ventricular beats.
- E. All of the above.

**2. The treatment would include:**

- A. Quinidine.
- B. Pronestyl.
- C. Digitalis.
- D. His bundle recordings and atrial pacing studies.
- E. Demand pacemaker.

(Answers on page 568)

# Editorials



## *Teenage Psychological Problems*

Few teenagers consult the physician with emotional problems. Yet, if the lay and scientific literature is any indication, they have plenty of problems.

The transition from childhood to adulthood is a difficult period further complicated by the fact that the teenager is "too big to throw a tantrum" and "too old to cry."

We assume that if we could get closer to them, we'd have a better mutual understanding. But most adolescents do not have a physician because it is costly, time-consuming, and they feel too embarrassed to seek help. Furthermore, many doctors do not have or are not willing to take the time to sit down and talk to a young man or woman like a Dutch uncle.

Surveys have demonstrated that most teenagers' problems are on an emotional basis. Physical ailments are not commonly seen in this age group because most teenagers are "disowned" and are floating in a sea of medical neglect. Yet, they have enough special medical and psychological problems to warrant our attention. Indeed, adolescent medicine is emerging as a subspecialty, not a stepchild of pediatrics.

Teenage psychological problems usually deal with excessive anxiety, depression, antisocial behavior, mood changes, and rebelliousness. Normal, in this period of life, when they are trying to find themselves. Anxiety often is sex-related and understandably, as awakening desires and strange new emotions cause feelings of worry and guilt.

Conflicts with parents, adult relatives, and teachers are bound to occur—especially if the

adolescent achieves personal individuality at the expense of others. Academic failures not only hurt his ego, they add to his insecurities. The ensuing problems often manifest themselves as physical complaints (headache, abdominal pain) and should not be taken lightly.

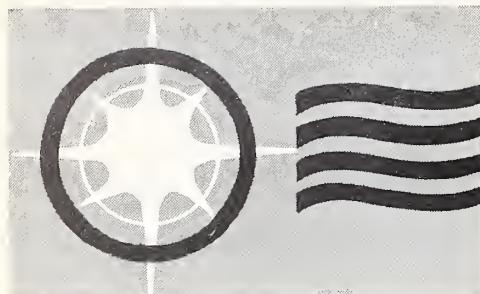
Drugs and alcohol abuse, nutrition, and dental care deserve high priorities as they have more serious future ramifications. Daily diet needs for growth and development are easily met with the four main groups of food. Obesity should be avoided and exercise promoted, especially when the teenager is addicted to TV.

Visual disorders, injuries, accidents, venereal diseases, handicaps, disabilities, and communicable diseases should be diagnosed and treated.

The adolescent is very sensitive. If he comes in with a parent, talk to each one separately. If the mother (or father) wants more information on the child's condition, suggest that she (or he) discuss it with their child. Obviously, much depends upon the diagnosis and the age of the boy or girl. Gaining his confidence improves the rapport between the physician and his young patient.

Bone and joint complaints (backache, joint pain, postural problems) also are common among adolescents. The latter often are related to rapid bone growth before the supporting muscles are fully developed and strong. Nagging him to "stand up straight" and "stop slouching" does very little good. What he needs is motivation.

T. R. Van Dellen, M.D.  
*Editor*



## membership forum



November 18, 1974

Dear Sir:

I have read with interest the Medical Legal Review, "Medical Malpractice: Viewpoint of a Plaintiff's Attorney" by J. B. Spence in the November, 1974, issue of this *Journal*.

I am vitally interested in the "malpractice situation" that particularly affects the State of Illinois and our patients, as they ultimately will pay the premiums which are growing out of proportion.

I take issue with our learned gentleman who feels that patients are going to lawyers because of legitimate complaints. I take extreme issue that settlement of cases would solve the problem. I feel very strongly that this is why we are in the problem we are in today because in the past we have paid off piecemeal to save ourselves litigation proceedings which, in most instances, would have been found in our favors. This is evidenced by the HEW Secretary's commission on malpractice report which has found that over 60% of suits filed were found against physicians. This

meant that they were counting the ones where claims were settled out of court as "nuisance value." It is no longer nuisance value; the score is against us. I think that we must fight everyone of these that is not clearly a malpractice. The error Mr. Spence makes in his analogy of stop signs is that medicine is not an exact art. It does not have clear stop signs and his estimation of when a stop sign has been transgressed is contrary to fact and contrary to nature. We must educate our patients to the fact that medicine is an inexact science. We cannot predict results and I think that patient expectations are too high due to rapid medical advances.

I am vitally interested in this subject and would be anxious to correspond with anyone of similar vein. I have written to the Illinois State Medical Society with some further thoughts concerning this and I would invite others to do the same to help reach a solution to this problem.

Sincerely,  
Peter McKinney, M.D.  
*President, Chicago Society of Plastic Surgery*

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*Ed. note: The following inquiry was received at ISMS Headquarters. This illustrates the vigilance needed by all physicians to protect the public.*

June 22, 1974

Gentlemen:

I am writing to you about a chiropractor, (name deleted).

This man is treating a patient that I also treated on a short hospital stay here in Mankato. The patient is a young man who has moderately severe classical hypothyroidism and very little else, perhaps some coronary disease but the EKG may well return to normal following replacement therapy. The hypothyroidism is primary with a rather marked elevation of the cholesterol

(. . .) is treating this young man with massive doses of vitamins, vitamins which must be purchased in Illinois and which cost the family \$60

per week. I cannot conceive of anyone consuming \$60 worth of vitamins per week if the vitamins are at anything like a fair price. As an M.D., I realize I have little chance of getting anywhere in an argument with a chiropractor and all the more so because the patient has complete confidence in the chiropractor and very little confidence in me.

I wonder, however, if the State of Illinois doesn't have a consumer advocate who might inquire into this man's activities. I, of course, suspect that he is getting a rather large kickback on the vitamin sales, but perhaps I am wrong.

Sincerely yours,  
Alois M. Scheidel, M.D.  
Mankato, Minn.

## Sue Me, Sue Me!

*"I do the very best I can, the very best I know how, and will continue to do so until the end."*—Abraham Lincoln, at a time of crisis in the Civil War.

I practice my specialty of plastic and reconstructive surgery in the same manner. I make mistakes, as I'm certain Lincoln also did. To keep abreast of changes in my field, I attend many national and regional plastic surgery meetings. I try to review every scrap of plastic surgical literature published in English. Since plastic surgery is a lesser specialty. At meetings, I have been able to meet true experts in all aspects of plastic surgery. If I have a real problem I call such an expert on the phone for advice and discussion. I sometimes suffer more than my patient over a bad result, so much so I have had them say they were sorry to disappoint me. I'm kindly about collections, and the only time I'm angry in the presence of the patients, often a cause of litigation it seems to me, is when I feel anger might produce cooperation (such as a smoker with leukoplakia.) I consider difficult patients a test; can I handle them better than their last doctor? I try to ask for help when I get a little out of the familiar; we all sometimes get trapped into our unknown if we try to expand our skills. I experiment only with the full and enthusiastic cooperation of the patient. If I am to be out of town (say between surgery and suture removal) I always tell the patient. My aid is more concerned than I when a patient needs help and I am not available. I never charge the patient for a second operation if the first was unsuccessful. ("My fee was to fix your ear, even if it takes 10 operations.") I have even refunded my fee on the very rare occasion when a patient has asked for it. As Lincoln said, "I do the very best I can and will continue to do so until the end."

As I analyze the reviews I read of malpractice settlements (not just suits, settlements) it seems to me that one of several things has happened: one doctor has run down the efforts of another; the doctor has become angry with the patient; or a patient has fallen into the hands of a suit-seeking lawyer. I've made a great effort to counter each of these as outlined above, but how to cope with the lawyers? I would like to present a possible solution to the problem.

What has the suing lawyer got to lose? Just a few hours of his time, and if he is not a very good lawyer he has plenty of that. If the lawyers can threaten us into making a settlement, can't we threaten them? Turnabout is fair play.

I have found it difficult to find a lawyer to suggest a charge other than defamation of charac-

ter, and that's a difficult one to make stick.<sup>1-3</sup> I talked the problem over with a double degree man. He suggested some possibilities. I am going to sue for "barratry," (O.E.D., vexatious litigation or incitement to it,) "malicious abuse of the due process of law," and "intent to make frivolous use of the courts." My suit against the lawyer will be for \$1,000,000, for the stakes have become high in the malpractice game. And \$1,000,000 is a nice round number. Lawyers all pooh-pooh this, saying I couldn't possibly win. Of course they would do all they could to protect another lawyer's source of income, but it wouldn't be the first time a pre-judgment was wrong. I honestly don't think I could win, but it would be fun to "try the case," as they say, "in the news media." Our local newspaper would love to have a "dog bites man" story. I am not sure what I would do with a million dollars if I did win. For one thing, I wouldn't have to share it with my lawyer. His fee will be substantial and in advance; no contingency fee arrangement for me. For all objections I hear to my plan I simply state "There is a first time for winning any type of suit." And if I lose—I can appeal and appeal—and appeal. Of the final court, five judges might just this minute be thinking about how malpractice suits have gotten out of hand and that defensive medicine is no kind of medicine for America. And one of those justices (Blackmun) served several years as legal officer at the Mayo Clinic. I am certain he would be more than understanding.

I've given this much thought, and I've begun to feel that it might give a little change and excitement to my rather routine practice. Fifteen years ago I gave up my practice for 10 months to take a Fullbright to teach plastic surgery in India. At the end of that time collections were still adequate to pay office expenses. If I could spend 10 months to create a deterrent to malpractice suits, it would certainly be as worthy a cause as teaching plastic surgery in India.

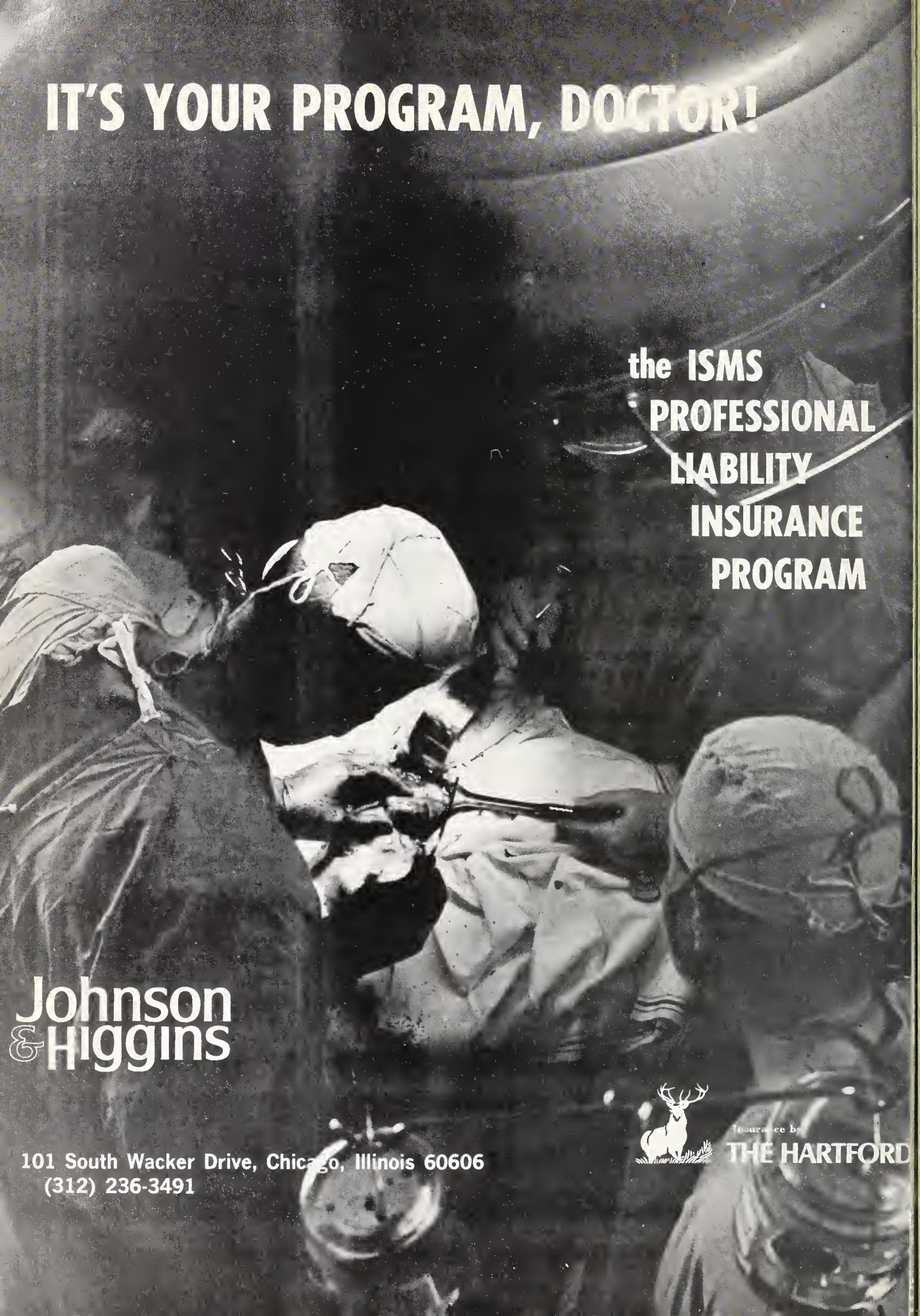
So, lawyer, sue me, sue me—but in the wording of British highway signs, "You have been warned!"

Hugh A. Johnson, M.D.  
Rockford

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1. Gorney, Mark: Countersue That Malpractice Accuser? Better Think Twice! *Medical Economics*, Sept. 3, 1973.
2. Carlova, John: He Sued His Malpractice Plaintiff For Libel—and Won! *Medical Economics*, June 21, 1971.
3. Reynolds, James A.: Doctor vs. Doctor, *Medical Economics*, March 4, 1974.

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# *Doctor's News*

**AMA DELEGATES REJECT DUES INCREASE**—The 247 member House of Delegates of the American Medical Association recently held its winter meeting in Portland, Ore. Among the resolutions considered was a proposed dues increase of \$90.00. The House of Delegates voted a \$60 one-year assessment, and to take up the matter of dues increase at the June meeting. The delegates also rejected the Board of Trustees plan to eliminate many advisory councils and committees and rejection "in principle" of the recommendation that advertising be banned in the group's publications.

**PROFESSIONAL LIABILITY**—A recent report in *Medical Economics* indicates that in the immediate future there will be an increase in malpractice claims. Some thoughts in the report, are interesting as "Doctors have gotten into trouble in the past for not referring to a specialist. Now they are being sued when they refer to a specialist who is not competent to handle the case." Product liability, deviation from standards of care for a specific illness as set by a specialty society—these are two areas of increasing concern.

Membership in the ISMS Sponsored Professional Liability program reached 4,502 as of the end of November. This is nearly half of the dues paying membership. Underwritten by the Hartford, and administered by Johnson & Higgins, this program incorporates local medical society review of problem cases and guarantees limitations on premium increase during the contract period.

**DRUG-RELATED DEATHS HIGH**—Cook County Coroner, Andrew J. Toman, M.D., reports a record high rate of drug-related deaths. The toll has almost doubled within a given year and the deaths are attributed to a combination of morphine, barbitubrates and alcohol. Dr. Toman states that lethal mixing of drugs seems to be one cause of the accelerating drug toll, which has authorities puzzled and alarmed.

**"MOCK DISASTERS" PAY OFF IN DECATUR**—Last July 19, the town of Decatur was struck by an explosion at the Norfolk and Western Railroad yards which killed two, injured over 140 and did \$8 million of damage. The victims of the disaster were fortunate to be cared for at the St. Mary's and Decatur Memorial Hospitals by personnel knowing how to react due to periodically held "mock disasters." Immediately upon knowledge of the incident, the disaster plans went into effect at the hospitals and the medical profession was notified. In fact, more than enough physicians volunteered their services. A field hospital was set up near the site of the explosion with a staff of 200 emergency workers, which handled the minor injuries. According to the news media in Decatur, the hospital personnel handled the situation extremely well. Norfolk and Western Railroad commemorated those physicians who contributed their time by presenting St. Mary's Hospital with a check; the physicians cited wish to remain anonymous.

The disaster on July 19 was the third in four months for the Decatur vicinity. In April a tornado struck causing one death, numerous injuries and millions of dollars in damage. And in May there was a flood with damage exceeding \$2 million.

## Dr. Schneider Elected President of Trauma Committee



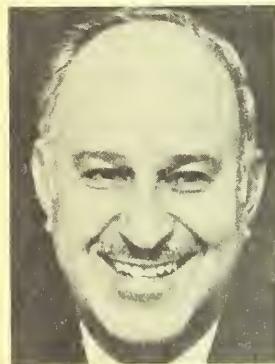
Howard W. Schneider, M.D., F.A.C.S., Harvey, has been elected President of the Chicago Committee on Trauma of the American College of Surgeons.

The orthopedic surgeon is President of the Medical Staff of Ingalls Memorial Hospital, Harvey. A Fellow of the American College of Surgeons and the American Academy of Orthopaedic Surgeons, Dr. Schneider

has designed special intramedullary nails for fixation of fractures and fusion of the hip joint.

Dr. Schneider is a graduate of the University of Illinois Medical School and is presently an Associate Professor in Orthopaedics at Northwestern University Medical School.

## Weiss Hospital Honors Dr. Siegel



Louis A. Weiss Memorial Hospital, Chicago, honored Alfred L. Siegel, M.D., Chicago, at its annual State of Israel Bond testimonial banquet, December 4, 1974. Dr. Siegel, Past President of Weiss Hospital, was saluted for his outstanding contributions to the hospital and for his dedication to the economic upbuilding of the State of Israel through the Israel Bond program.

## Dr. William Ford Retires



William K. Ford, M.D., Rockford, recently retired after dedicating 47 years to the medical profession. A graduate of Loyola University Stritch School of Medicine in 1924, Dr. Ford began his practice in Rockford in 1927. The dermatologist was President of the Winnebago County Medical Society in 1948 and one of the original members of the American Academy of Dermatology.

He was one of the founders of the Rockford Blue Shield program and served as President of Medical-Surgical Service of Illinois from 1964-1970.

Dr. Ford will continue to serve on the faculty at Rockford School of Medicine and remain active in the Winnebago County Council on Aging, which he organized in 1965.

**PHYSICIANS IN THE NEWS**—Get well wishes are extended to William M. Lees, M.D., Lincolnwood, who is recovering from surgery. Dr. Lees is ISMS Trustee to the Third District and is immediate past Chairman of the ISMS Board.

John W. Curtin, M.D., Chairman of the Department of Plastic and Reconstructive Surgery at Rush-Presbyterian-St. Luke's Medical Center, Chicago, has been elected to a four-year term on the Board of Governors of the American College of Surgeons.

New Diplomates of the American Board of Anesthesiology are: Edward F. Anderson, M.D., Libertyville; Yvetot Antoine, M.D., Chicago; Millan C. Baidya, M.D., Aurora; Rahim Behnia, M.D., Northbrook; Peter A. Conrardy, M.D., Great Lakes; M. Julia Dos-Santos, M.D., Chicago; Hedayatollah Elyassi, M.D., Forest Park; Jack Friedman, M.D., Champaign; Ronald K. Grossman, M.D., Glencoe; Ronald D. Kilzer, M.D., Chicago; Robert H. Libman, M.D., Chicago and Alfonso Y. Wong, M.D., Chicago.

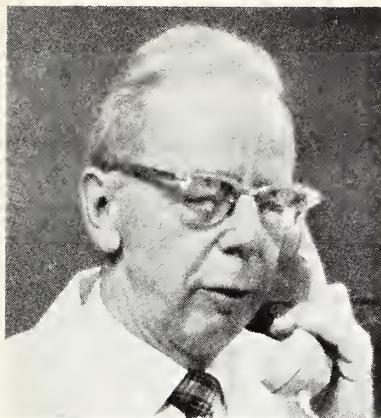
## Award Bestowed To Dr. Irving Shapiro



LeRoy A. Pesch, (left) President of the Michael Reese Medical Center, Chicago, is pictured above presenting the President's Medal to Irving J. Shapiro, M.D., Chicago.

The President's Medal is the highest award bestowed by the Michael Reese Medical Center for "outstanding contributions to the health and welfare of mankind."

Dr. Shapiro, a noted urologist, is past president of the Chicago Urological Society and a former president of the Michael Reese Medical Staff.



## President's Page

# Cooperation And Concern

**EDITOR'S NOTE:** Dr. Lake recently addressed the annual meeting of the Illinois Hospital Association (IHA) and called for continued cooperation between the IHA and Illinois State Medical Society. Dr. Lake cited these recent joint actions by IHA and ISMS: (1) Formation of a Blue Ribbon Task Force to attack the problem of slow Medicaid reimbursement; (2) Co-sponsorship of a "Trustee-Administrator-Physician" (TAP) institute which focused upon the development and implementation of programs to assure quality of care in hospitals; and (3) Formulation of a statement informing physicians of their obligation to maintain sufficient liability insurance coverage, but indicating that the medical staff—not the hospital administration—is responsible for insuring such coverage.

During his address, Dr. Lake also expressed the concerns of many physicians regarding hospital operations. The following is adapted from that portion of Dr. Lake's speech.

Physicians are concerned about the concerted efforts of some hospitals to extend their tentacles and capture an even larger share of the health care "pie."

Two disturbing examples of this aggressive posture are the substitution of more costly hospital out-patient facilities for the physician's office, and the establishment of satellite hospitals in outlying areas. Perhaps these hospitals are trying to justify the term "health care industry." But, is it fiscally responsible for our hospitals to mimic industry in this regard?

We also are concerned about lush growth in the administrative overburden of our hospitals which is encouraged by the "cost plus" philosophy of reimbursement. From my vantage point, the ever-expanding administrative empires appear to devote too much of their efforts to managing, and too little to supporting professional services. "Busy work" seems to be the order of the day and crucial decisions dally through interminable meetings and countless committees.

Moreover, we physicians never cease to be amazed at the ease with which funds are found to augment the many-titled staff of managers and their bevy of assistants—while professional services are forced to do with inadequate personnel, or wage an unbelievable paper-war of justification.

Many of us have the very distinct feeling that the "cult of management" which has taken over your field in recent years has contributed very considerably to the budget bulge hospitals have exhibited without any perceptible improvement in patient care.

A further concern is hospital-based HMOs and their potential for competing with voluntary

medical staffs. We believe hospitals should not undertake such an endeavor without the approval of their medical staffs.

Perhaps the essence of all our concern is the haunting suspicion that the hospitals' underlying objective is to control the practice of medicine and bury private practice.

Credence is lent to this suspicion by the ever-increasing ranks of salaried hospital physicians, whose services often are sold on a basis designed to fatten the hospital coffers.

These are some of the misgivings generated by what we see happening in our hospitals. The mistrust engendered must be resolved so that IHA and ISMS can continue to move forward together in joint effort to cope with government threats which would deprive us both of freedom in conducting our affairs and exercising our professional judgment.

One other area which threatens the well-being of hospitals and physicians alike is the malpractice assault. Urgent, vigorous and collective action is needed. Professional liability insurance is not solving the problem, it is part of the problem. It is time to launch a massive counter-attack on several fronts and to plan this operation, we need a joint Blue Ribbon Committee.

Let's move on from our small beginning in cooperative efforts. Let's continue to talk together, plan together, and work together.

Fredric D. Lake, M.D.

## Doctors Save Lives By Telephone

MediPhone, an innovative new medical information and consultation service, is helping the nation's doctors save lives and treat patients more effectively. Twenty-four hours a day, seven days a week, MediPhone responds to calls from doctors who are confronted with perplexing medical problems or patients who have failed to respond to treatment.

This nationwide physicians' telephone consultation service immediately puts the inquiring physician in touch with an expert in a medical specialty. The MediPhone service offers the best in consultation and breaks down distance and time barriers, all at a fraction of the usual consultation fee.

The Chicago-based MediPhone program demonstrates its life-saving potential almost daily. Recently a doctor in a small northern Illinois community was called to treat a patient who had been bitten by the deadly brown recluse spider. This species has only recently migrated from the South to the northern parts of the country. It requires a minimal temperature of 40° F to survive. Thus, in colder climates it may be found in such places as closets and basements. The physician who called MediPhone had never encountered a similar case and requested information on the treatment of the bite of this poisonous spider. Time was critical; delay would cause much suffering and even endanger the patient's life.

The attending physician immediately dialed the nationwide MediPhone physician's consultation service telephone number: (312) 782-7888. Moments later he was in consultation with an expert toxicologist at The University of Texas Medical Center in San Antonio. The expert informed the calling doctor that the modern management of the recluse spider bite required a wide excision since the bites are multiple, and the administration of large doses of cortisone. Within hours, the patient had been treated according to the plan outlined by the consultant. The immediate application of these life-saving measures undoubtedly saved the patient from a great deal of pain and possible death.

MediPhone also performs educational and consultative services for non-emergency calls.

MediPhone was originated in 1972 by its director, John G. Bellows, M.D., a Chicago eye specialist. The service is sponsored by the non-profit American Society of Contemporary Medicine and Surgery, a 7,000-member physician organization whose purpose is to disseminate the latest medical information to doctors. Among the leaders of the Society and MediPhone are the

chairman, Morris Fishbein, M.D., medical author and former editor of the *Journal of the American Medical Association*, and the president, Michael E. DeBakey, M.D., leading heart surgeon. The more than 600 consultants are located in some 60 university medical centers throughout the country. These include deans of medical schools, heads of departments, and outstanding specialists in all field of medicine and surgery.

The Society and MediPhone are approved by the American Medical Association for continuing medical education. Therefore, the physician who uses MediPhone not only obtains medical information and consultation, but he also receives a certificate for credit hours in continuing medical education.

Our main motive is to help doctors practicing in an area where they have difficulty keeping pace with the best and most advanced medical care possible. However, the program is not a substitute for the consultant who personally reviews the patient's hospital chart, elicits a medical history, and examines the patient. Rather, it is intended to overcome barriers of distance and allows doctors to consult readily with experts on medical problems that may be unusual and baffling. Frequently the caller has need of information that may not yet have been published. MediPhone can provide physicians with the latest treatments available long before they appear in printed form.

MediPhone is available only to physicians. The charge for a MediPhone consultation is \$25, from which the consultant receives a fee for his services. The charge for the consultation can be included in the patient's bill and may be covered by his health insurance carrier. MediPhone ultimately should help reduce the rising cost of medical care. Doctors who use MediPhone can provide better care for their patients, and better care is usually cost-saving in the long run.

MediPhone, the first and only nationwide physicians' telephone consultation service in operation, recently received a regional development grant from the prestigious Robert Wood Johnson Foundation. This grant will help pay for the administration of MediPhone and make its services better known to physicians. Current plans are to mail individual membership cards to physicians. It is hoped that wider use of MediPhone's resources will enable physicians to administer better health care to the public.

The American Society of Contemporary  
Medicine and Surgery  
30 N. Michigan Ave. Chicago 60602

# The Suicide Assessment Team (SAT) In A General Hospital

BY ROBERT I. YUFIT, Ph.D. AND S. DALE LOOMIS, M.D./CHICAGO

Suicide remains a leading cause of death in the United States, even though only a fraction of suicidal deaths are so recorded. Both the taboo aspect of suicide, and the fact that many suicides are listed as accidental deaths, account for this underestimation. Thus, while over 25,000 suicides were recorded in 1971, conservative estimates place the actual number of suicides at at least twice that number. There are more than 200,000 suicide attempts and 800,000 threats annually. To this one-million-plus figure of overtly suicidal persons, we can consider a minimal involvement of three other persons, which means the ripples of suicide can be seen to involve directly over four million people. The problem of suicide is indeed a major one and it is growing.

Often, suicide attempters create difficult problems for hospital medical staff, either as new admissions to emergency room or psychiatric units, or when suicidal ideation or threat occur in a medically hospitalized patient. The urgency of immediate intervention of a nonmedical nature, plus the difficulties in managing such patients, usually creates problems for hospital staff, and a strain on hospital procedures, which have been established primarily for medical treatment. Problems include the valid assessment of suicide potential, the danger the patient poses to self and to others, management of the actively suicidal patient, and staff's own feelings and anxieties in dealing with the ambivalence of such patients.

Many suicidal emergency room patients are treated only for the medical injuries of their suicidal act, but all too often, the psychological wounds are not attended to, and remain infected to cause later problems, including subsequent suicide or readmissions.

## Purpose of Program

The Suicide Assessment Team (SAT) program has been created to help with the above cited

ROBERT I. YUFIT, Ph.D., is Project Director of Suicide Assessment Team (SAT) at Illinois State Psychiatric Institute, and consultant coordinator for SAT at Illinois Masonic Medical Center and Katherine Wright Psychiatric Clinic. Dr. Yufit is a Diplomate in Clinical Psychology and a Regional Board member of the American Board of Professional Psychology.

S. DALE LOOMIS, M.D., is Chairman, Department of Psychiatry at Illinois Masonic Medical Center, Chicago, attending psychiatrist at St. Joseph Hospital and Director, Katherine Wright Psychiatric Clinic. Dr. Loomis, a Diplomate of the American Board of Psychiatry and Neurology, is the Chairman of the ISMS Council on Mental Health.

problems. To our knowledge, the SAT is an innovative concept in specifically dealing with the suicidal patient. SAT is part of the Department of Psychiatry in a general hospital and consists of a group of specially trained consultants. The SAT has a variety of functions:

1. Consultation to hospital staff in the evaluation of suicide attempters who are:
  - a. admitted to the emergency room
  - b. general inpatients, including intensive care
  - c. psychiatric inpatients
2. Interview suicidal patients to evaluate suicide potential and to make recommendation and referral;
3. On a selective basis, offer more elaborate psychological assessment of suicide potential by specially devised psychological techniques;
4. Education and training of pertinent hospital staff (social service, nursing), in assessing suicide potential; to know when to call an SAT member in the management of suicidal patients; and handling their own staff's feelings;
5. Training of psychology interns to use specially devised assessment procedures to evaluate suicidal potential;
6. Conduct a psychological autopsy meeting following an inpatient suicide; and
7. Research of the assessment techniques developed, defining the psychodynamics of suicide, with publication of significant findings.

The consultative services are available to patients who have made overt suicide attempts and gestures, as well as those who express suicidal

ideation and threats.<sup>1</sup> In fact, it is now hospital policy to make a referral to SAT whenever a suicide attempt or gesture is made. All overdose patients are considered suicidal until revealed otherwise. The SAT also can be consulted in instances of marked clinical depression, where suicidal thought or behavior may be inferred by hospital staff as a reaction to certain stress situations (such as postsurgical reaction). In terms of settings, the three most frequent sources for referrals are:

1. Patient makes suicide attempt and is admitted to medical or psychiatric unit;
2. Patient is seen in emergency room, but not admitted to hospital, or, admission is considered; and
3. Patient is in hospital for another reason and becomes suicidal.

### Procedures

The SAT consists of a multidisciplinary group of professional personnel, experienced in working with suicidal patients. The SAT includes social workers, psychiatrists, psychologists, and nurses. As increased financial aid becomes available to allow staffing increases, it is hoped that an SAT member will be available 24 hours every day. Currently, only limited evening, night, and weekend coverage is offered. Weekday coverage is fulltime.

Consultations can be initiated by the attending psychiatrist or another M.D., staff psychologist, social worker, house staff, or supervising nurse of the unit or emergency room. All pertinent information regarding the suicidal patient is conveyed to the SAT by telephone and supplemented by completing forms which list important content areas considered related to suicide (declared intention, risk [lethality] of method used, reversibility, chance for rescue, degree of planning, precipitating event, degree of injury, previous suicide acts).

Two kinds of consultation occur. An *emergency consultation* is one requiring immediate intervention. The SAT member in the emergency room notifies the psychiatrist on call if the patient needs psychiatric hospitalization. Emergen-

<sup>1</sup>A suicide attempt is a highly lethal act at conscious self-destruction; a gesture is an act of low lethality in which the consequence is less likely to be death, and the act is more for the purpose of attention seeking or punishing oneself. However, suicidal gestures are not to be taken lightly, and should be evaluated in the same manner as the suicide attempt. Ideation is thinking about suicide, while threats are verbalizations of such thoughts.

cy consultations are automatic following an overt suicidal attempt. For inpatient SAT intervention, a written request for consultation follows phone contact, for record purposes. Because night coverage is currently limited, SAT may not always be able to provide immediate consultation, but usually does so by the following day.

A regular consultation of an inpatient is initiated by the attending physician or the supervising nurse. An appointment is set as soon as possible. Recommendations made by SAT are entered on the patient's chart using an SAT form and psychological evaluations of patients seen by SAT are maintained in a central file.

Decisions to be made involving transfer of a medical patient to psychiatry, or use of special suicide precautions, are made in accordance with hospital policy. In instances involving a private patient, the consultation is in collaboration with the attending physician. The SAT psychiatrist and psychologist are almost always involved in the evaluation. The minimum evaluation will include a focused interview with the patient by SAT member, and, if possible, talking with accompanying relatives or friends. The focus is aimed at such content areas listed above, as well as assessing current psychological status. *This is a Level I assessment.*

*Level II* assessment would add the use of formal rating scales of suicide intent and depression. A *Level III* assessment includes interview, rating scales and special psychological assessment techniques. These techniques include measures of time perspective, self-concept, interpersonal relations, including degree of intimacy, trust, and others.<sup>1,2</sup> These three levels of evaluation are detailed in the SAT Manual of Procedures.<sup>3</sup>

The major aims accomplished by the SAT programs are: (a) to make a valid assessment of the patient's suicidal potential; (b) to respond to the indicated needs of the patient; (c) to make an appropriate disposition of the referral; (d) to educate and train staff to perform initial screening of suicide potential; and (e) to gather data for research. Such research includes the refinement of a suicide assessment battery of psychological procedures and theory building based on empirically derived psychodynamics.

No concerns need be generated by the functioning of the SAT as a substitute for a general psychological evaluation, or for psychiatric evaluation, but rather SAT lends its expertise to a collaborative effort in the form of a specialized consultation, in helping assess suicidal potential and planning for the suicidal patient.

In situations where there is a clear threat of

either self-destruction or homicide, psychiatric commitment can be implemented by usual hospital procedures.

Where outpatient services are indicated, referral is made to nearby outpatient clinics, to existing municipal mental health centers in the area, or to qualified independent accredited psychotherapists. A list of available psychotherapists is maintained for this purpose.

### Limitations

The SAT does not handle crisis situations other than suicidal ones. In situations where referral is by phone call from the suicidal patient or interested parties, the patient *must* be brought to the hospital for evaluation, as the SAT is not currently constituted as a mobile task force.

Long term treatment of referred suicidal patients is not available by the SAT, at this time.

The SAT is not a suicide prevention program

but rather a suicide *intervention* program. In its first six months SAT has seen over 100 patients and made recommendations in each case. Although no formal follow-up has yet been implemented, about two out of three patients follow recommendations made. Thus far, only one patient (chronic drug abuser) has subsequently committed suicide by an overdose. A follow-up study will be conducted to evaluate the validity of the clinical assessments. An evaluation of the existing program will be made after one year to determine its effectiveness. ▀

### References

1. Yufit, R. I., et al: Suicide Potential and Time Perspective. *Arch. Gen. Psych.* v. 23, Aug. 1970, pp. 158-163.
2. Yufit, R. I. and Benzie, B. Assessing Suicide Potential by Time Perspective. *J. Life Threatening Behav.* v. 3, Winter 1973 (270-282).
3. Yufit, R. I. and Gross, R. SAT Manual of Procedures. Private distribution. 1973.

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# The Education of an Intern

The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

Education, the primary function of an internship, is too often forgotten in spirited debate of the role of house officers, their rights, privileges, and obligations. Amid the complexities of national health insurance, peer review and rising medical costs, education must not be lost. While many training institutions admirably fulfill this basic premise of graduate medical education, some fall short of providing even the most rudimentary form of teaching. In some cases, this shortcoming is due to oversight or lack of suitable supervision. Regrettably, in others it is due to an institutional attitude that housestaff are a form of inexpensive labor which can provide certain services to the patient, and their education is of secondary importance.

*Essential of an Approved Internship*,<sup>1</sup> a document which contains the minimal requirements for an approved internship, is lengthy, but segments of it are particularly noteworthy in this context:

"While the internship combines two functions—an educational period in the training of young physicians and a position rendering medical care and service to patients in hospitals and assistance to the staffs of hospitals—its educational function is of primary importance and its service function is secondary and incidental."

Unfortunately, while many institutions offer "lip-service" to this doctrine, they fail to live up to its educational demands. Most recent studies have shown that house officers spend approximately 75% of their time on service-related duties, and only 25% or less of their time involved in educational activities. In some instances, it is difficult to separate service and educational activities, but there is no doubt that onerous repetition of the simplest mechanical tasks is of little educational benefit.

In some training institutions, there are private physicians who rarely, if ever, participate in the education of the housestaff, and who resent housestaff playing an active role in the care of their patients.

"In the event that the physician in charge does not wish to have his private patients used for teaching on the same basis as non-private cases, he should not expect the intern to assume responsibility for the history and physical examination or for any other routine procedure."

While this doctrine seems reasonable, it is difficult to imagine any attending physician being called into the hospital in the middle of the night to start an intravenous solution or to draw blood gases on his patient because the intern refused to perform this "routine procedure."

"It is fundamental that the staff recognize its obligations to permit full utilization for teaching purposes of all patients, whether private or non-private, to whom interns are assigned. If this concept cannot be accepted without reservation, the hospital staff ought not to attempt to conduct an internship program."

In this country there are many non-teaching hospitals and relatively few teaching hospitals. In the event that a staff physician will not or cannot allow his private patients to be used for teaching purposes it seems reasonable that he would change his hospital affiliation to a non-teaching hospital; yet, this is very often not the case. Many of these physicians wish to continue to reap the benefits of 24-hour housestaff coverage while failing to return even a modicum of training experience to these house officers. While it is

recognized that not all physicians wish to participate in teaching programs, nor are they qualified to participate in them, the appointment to the staff of a teaching hospital carries with it certain obligations. High on the list of these obligations is the teaching of the housestaff.

"The most important phase of intern instruction consists in regularly organized daily ward rounds, with well-conducted teaching at the bedside. By this is meant systematic instruction of the intern by the attending physician, with an ample discussion of the history, the physical examination, the clinical and laboratory findings, the diagnosis, and the treatment of each patient. . . It is the duty of the attending physician in direct charge of the patients assigned to the intern to conduct such teaching. It cannot be delegated to others, though it should be supplemented by supervision of the intern's work by the director of intern education, junior staff members, and residents."

Fortunately, most attending physicians at teaching hospitals are quite dedicated to the teaching of their housestaff. They are tolerant of the intern's fumblings as he tries to master the art of medicine and gently but firmly guide him through his educational experience. Without these skilled mentors, graduate medical education would have ceased many years ago. Nonetheless, there are other attending physicians at these institutions who seem to have little interest in the educational process. It is these few who should seriously consider what their role in graduate medical education is and what it should be. If they cannot participate in the education of the house officers, then they should take their patients elsewhere, and not burden the housestaff with the routine chores which are of only token educational value.

The interns have obligations as well. They should listen respectfully and attentively to their teachers, realizing the importance of this part of the educational process. They should read the literature and be conversant with the academic aspects of medical care. In this way, an attending physician can properly teach the art and need not dwell on the simplest basics.

"He (the intern) should receive instruction, information, criticisms, advice, suggestions, and assistance from his superiors, who thus contribute to his education."

The intern must not forget the primary reason for his presence—*education*. He must not be overly sensitive to criticism and advice from his teachers, for they are trying to educate him. He must not resent performing some routine tasks in the interest of patient care, for this is also part of his responsibility.

If education is to remain the primary goal of post-graduate hospital appointments, housestaff and attending physicians alike must actively participate in the education. There is no place in a teaching hospital for attending physicians who are unwilling to teach, or housestaff physicians who are unwilling to learn. In spite of rapid changes in medical economics, medico-legal problems, and social challenges, medical education must not be forgotten. ▀

## Reference

1. *Essentials of an Approved Internship*, Council on Medical Education of the American Medical Association, 535 North Dearborn Street, Chicago, 1972.

## Boutonnière Deformity (Continued from page 533)

The most commonly seen causes are rheumatoid arthritis and trauma. Boutonnière deformity is reputed to be present in about one-third of the patients with rheumatoid hand deformity.<sup>14</sup>

### Treatment

Treatment in early cases may be splinting or surgery. The old and chronic case may require surgery with fusion. The details of the treatment are beyond the scope of the article and are available elsewhere.<sup>4-9,11,13,15</sup>

### Summary

The Boutonnière deformity of the finger is described. Its roentgen appearance, pathoanatomy and etiology are discussed. ▶

### References

A complete bibliography for Boutonnière Deformity may be obtained by writing the *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago 60601.

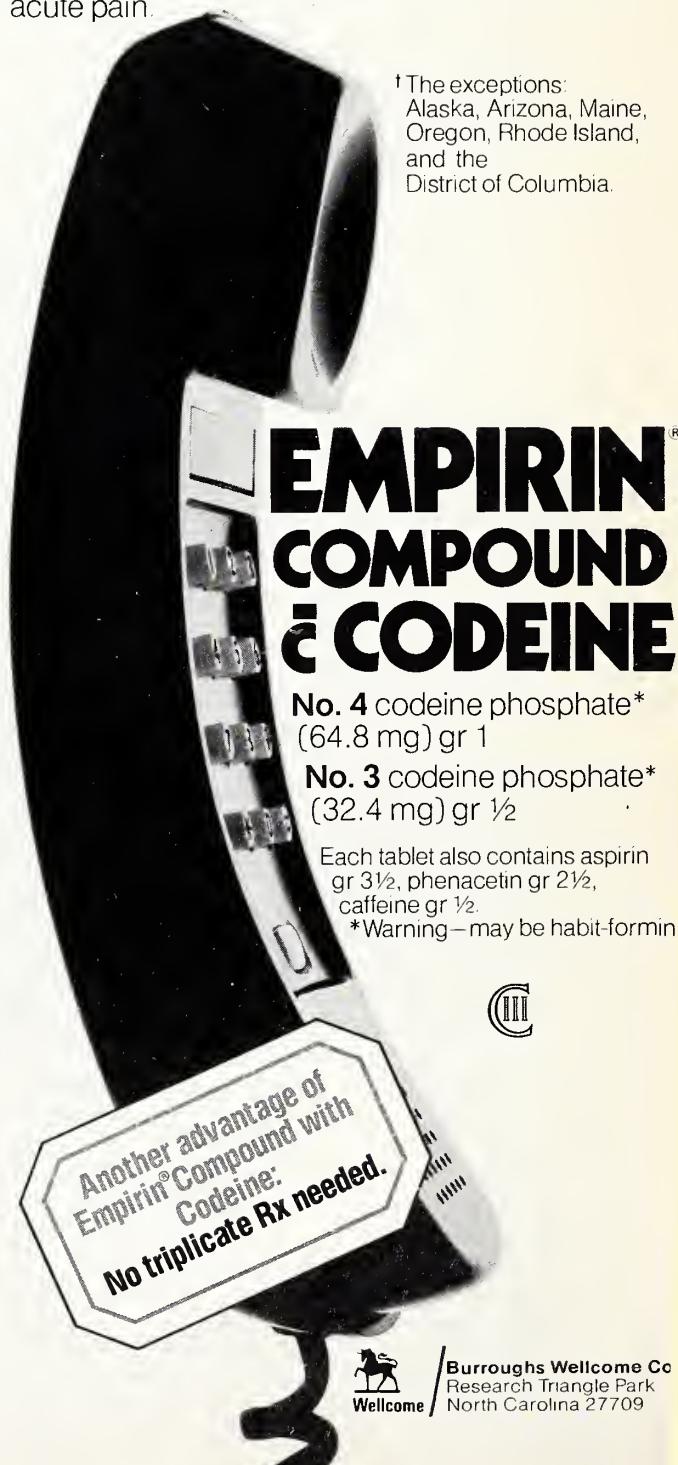
### Coronary Surgery

What about surgery? The operative mortality of coronary artery bypass surgery in patients with unstable angina pectoris has varied from 0 to 24% in over 20 reports, with the average being comparable to that reported for stable angina pectoris, 5 to 7%. Indeed, this low hospital mortality, coupled with a 70 to 80% likelihood that angina pain will be relieved, has prompted many physicians to call for emergency bypass surgery in these patients "before they infarct." Yet the vast majority of these patients "quiet down" on medical therapy in the hospital. Furthermore, many papers report a 15 to 20% incidence of perioperative myocardial infarction with coronary artery bypass surgery. Finally, all these reports have been from uncontrolled and nonrandomized studies in which patient selection was variable. There is also little information on late follow-up, graft closure rates, and the incidence of late angina and myocardial infarction among these patients. Thus, the major question is whether medical or urgent surgical therapy is the better form of therapy over the long run in terms of survival without myocardial infarction, angina or unacceptable side effects from the therapy in question. The answer is not known at this time. (Adolph Hutter, Jr., Finding the Right Key to Unstable Angina, *Medical Opinion* (Nov) 1974, pgs. 16-19.)

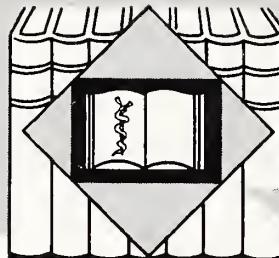
# The Pain Phone

When a telephone prescription for pain relief is necessary or convenient, you can call in your order for Empirin Compound with Codeine in 45 of the 50 states! That includes No. 4, which provides a full grain of codeine for more intense, acute pain.

† The exceptions:  
Alaska, Arizona, Maine,  
Oregon, Rhode Island,  
and the  
District of Columbia.



# the doctor's library



**REVIEW OF PEDIATRICS**, edited by Henry L. Barnett, M.D. and Arnold H. Einhorn, M.D., published by Appleton-Century-Crofts, 15th Edition.

The most recent edition of Dr. Barnett's standard pediatric reference book now has in excess of 2,000 pages of concentrated information about the peculiarities of providing effective medical care for children. It should be noted that in addition to more pages, the size of the type has been reduced, which may pose some problems for older eyes. There has been quite a change in the organization of the material presented over the last two editions. The current organization of the book moves from general aspects to the more particular facets of organ system disease as you go through the book. Particularly welcome is an excellent section on Perinatal Medicine reflecting the increased emphasis given to good pediatric care prior to birth of the infant. Increased emphasis on application of the science of genetics in pediatrics merits a section on General Genetic Principles leading to examination of specific inherited syndromes. In general, the sections reviewed were very readable with good reproduction of diagrams and charts.

The final chapter by Dr. Einhorn relates to an outline of general health care of infants and children, concluding with a short monograph urging the "complete pediatrician" of the present and future as ecologists of the family unit. I would wish that this section had contained information relating to the techniques of accumulating modern records and in particular, a description of how one might apply the problem oriented record to general child care practices.

In summary, the book maintains the usual high level of quality expected for this standard reference text. If the next revision results in the addition of a few hundred pages, one would hope the publishers would consider a two volume book with more easily readable type.

Thomas J. Egan, M.D.

**ORTHOThERAPY**. Arthur A. Michele, M.D. and Shirley Motter Linder, M.S. New York, M. Evans and Company, Inc., 1971. Price \$6.95.

This book, written for the lay public, describes how postural abnormalities arising in childhood lead to multiple system symptoms in later life. The author includes a self-testing quiz for the reader which suggests that those readers requiring a daily exercise program can identify themselves. A chapter on physical self-testing for adults permits self-identification of postural contractures and another chapter describes physical examination of infants and children, focusing on the spine and lower extremities.

The author believes that an iliopsoas contracture is the common denominator in most postural problems and devotes a chapter to a series of exercises, designed to improve general physical conditioning, terminating with specific exercises to stretch the iliopsoas muscle.

A chapter titled "Orthopaedic Problems in Children" discusses congenital torticollis, congenital dislocation of the hip, coxa vara, Legg-Perthes' disease, slipped femoral epiphysis, round back, spondylolisthesis, scoliosis, clubfeet, bowlegs, knock-knees, recurrent dislocation of the patella, and foot disorders. In each discussion the author points out the necessity of an exercise program in conjunction with the orthopaedic treatment.

My skeptical appraisal is that the reader, coached in self-diagnosis, will misinterpret the use of an exercise program as an adjunct to treatment and perhaps delay medical evaluation, relying entirely upon the exercises described in the book. Major criticism of this book is that self-testing, self-examination, and self-diagnosis are over-emphasized. The exercises described in the book have been expertly selected, are beautifully described to the reader, and are diagrammatically well-illustrated.

John Romine, M.D.

**EARLY CARE OF THE INJURED PATIENT**, Committee on Trauma of the American College of Surgeons. W. B. Saunders Company, Philadelphia, 1972.

In 1931, the American College of Surgeons first published a manual on the treatment of fractures. Combined with another manual outlining the management of soft tissue injuries, this book has subsequently become a classic which is read and studied by students, residents and surgeons throughout the country. The 1972 edition will serve only to reinforce the prevailing opinion that the **EARLY CARE OF THE INJURED PATIENT** sets the standard of excellence in the field of trauma.

As the title implies, this book does not pretend to be an all encompassing volume covering the entire field of trauma. Emphasis is placed on the diagnosis and early management of common injuries. Thus, one finds chapters which discuss the current concepts of shock and cardiopulmonary resuscitation while such subjects as rehabilitation are notably missing.

The entire approach is directed at the clinician. For example, rather than embroil the reader in the intricacies of bacterial growth, the chapter on "Infection" states simply, "Infection is the unfavorable result of the equation of bacterial dose multiplied by virulence and divided by the resistance of the host." Topics of pertinent interest such as the current management of tetanus and gas gangrene are fully discussed. Another chapter, entitled "Bites", not only includes the management of human and dog bites, but also includes a discussion of snake and spider bites. This provides the reader with the practical information needed to recognize and treat these less common but equally important injuries.

As in the past, a large portion of the book is devoted to the management of fractures. The excellent chapter entitled, "General Principles of Fracture Treatment," concludes with a list of 18 aphorisms which simply and directly state the most important principles of fracture care. Strict adherence to these principles will prevent many of the disastrous complications which all too often begin with the patient's initial treatment. Most of the common fractures in children and adults are described. Supplemented by excellent line drawings, the mechanism of injury, diagnosis and treatment of each fracture is carefully presented. Rather than present an exhaustive review of each subject, the authors describe one or more methods of treatment for each fracture which have proven successful in most circumstances.

**THE EARLY CARE OF THE INJURED PATIENT** should be found in every hospital emergency

room and in the library of every surgeon. The knowledge so clearly presented in this little book is as important to the student of trauma as the stethoscope is to the cardiologist.

Stuart M. Poticha, M.D.

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**THE PRINCIPLES AND PRACTICE OF MEDICINE**. 18th Edition. Edited by A. McGehee Harvey, Richard J. Johns, Albert H. Owens, Jr., and Richard S. Ross; Appleton-Century-Crofts. Educational Division/Meredith Corporation, New York, 1972. Illustrations, 1599 pages, and index. Price \$24.50.

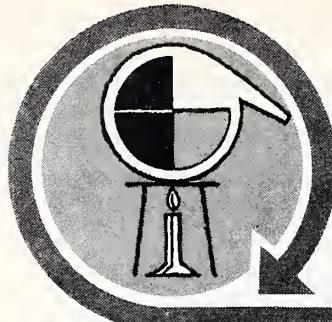
I have a first edition of Sir William Osler's *The Principles and Practice of Medicine*. Since 1892, it has been so extensively revised that there is no comparison to the 18th Edition published last year under the editorship of four Johns Hopkins professors of medicine. We purposely delayed writing this review—not because the book is 1599 pages, but because we wanted to judge its usefulness after referring to it repeatedly for answers to various medical questions.

The book is not an encyclopedic text and, in this respect, does not duplicate existing medical textbooks. It is a volume built around the patient and involves diagnosis, management, and prognosis. To be specific, it contains the material that is taught medical students at The Johns Hopkins University School of Medicine and should be entitled, "The Johns Hopkins Textbook of Medicine." Certain earlier reviewers who expected a more balanced type of textbook may not have taken this into consideration.

Physicians who earned their degrees 10 or more years ago will be interested in this book because it brings them up to date. For my purposes, it was made to order because it stresses what the modern student of medicine should know. The volume contains current material on immunity-related diseases and the numerous heritable disorders associated with medical genetics. Many of the 155 chapters deal entirely with the significance of specific symptoms and findings. Examples include seizures, headaches, psychologic illness related to physical illness, abdominal pain, obesity, and cardiac arrest, etc. New chapters on alcoholism and hyperlipidemias also have been added.

Ample charts and tables simplify contrasting clinical features, laboratory tests, differential diagnosis, and therapy. It is an excellent book for the student of medicine and the practitioner who is patient oriented.

T. R. Van Dellen, M.D.  
Editor



# new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**Single Chemicals**—Drugs not previously known, including new salts.

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### NEW SINGLE DRUGS

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|----------------------|--|----|
| <b>MOBAN</b>         | Tranquilizer   | Rx |
| Manufacturer:        | Endo Laboratories, Inc.  |    |
| Nonproprietary Name: | Molindone HCL  |    |
| Indications:         | Management of manifestations of schizophrenia  |    |
| Precautions:         | Drowsiness may occur during early therapy  |    |
| Adverse Reactions:   | Consult package insert   |    |
| Dosage:              | Mild: 5 to 15 mg. t.i.d. or q.i.d.<br>Moderate: 10 to 25 mg. t.i.d. or q.i.d.<br>Severe: up to 225 mg. daily may be required |    |
| Supplied:            | Tablets, 5, 10, and 25 mg.   |    |
| <b>MOTRIN</b>        | Antiinflammatory Agent   | Rx |
| Manufacturer:        | The Upjohn Company   |    |
| Nonproprietary Name: | Ibuprofen  |    |
| Indications:         | Chronic symptomatic Rheumatoid Arthritis and Osteoarthritis  |    |
| Contraindications:   | Hypersensitivity to the drug; syndrome of nasal polyps, angioedema and bronchospastic reaction to aspirin.                   |    |
| Warnings:            | If gastrointestinal intolerance occurs lower the dose; antacids may be tried.  |    |
| Dosage:              | 300 or 400 mg. t.i.d. or q.i.d., adjust to patient's response.   |    |
| Supplied:            | Tablets 300 and 400 mg.  |    |

### DUPLICATE SINGLE DRUGS

|                      |   |    |
|----------------------|---|----|
| <b>LITHOTABS</b>     | Antipsychotic                               | Rx |
| Manufacturer:        | Rowell Laboratories, Inc.                   |    |
| Nonproprietary Name: | Lithium Carbonate                           |    |
| Indications:         | Manic episodes of manic depressive illness. |    |
| Warnings:            | Follow package insert                       |    |
| Dosage:              | Follow instructions in package insert       |    |
| Supplied:            | Tablets, 300 mg.                            |    |

### DUPLICATE BIOLOGICAL DRUGS

|                         |  |    |
|-------------------------|--|----|
| <b>HYPERAB Globulin</b> | Biological   | Rx |
| Manufacturer:           | Cutter Laboratories  |    |
| Nonproprietary Name:    | Rabies Immune Globulin (Human)   |    |
| Indications:            | Persons suspected of exposure to rabies                                |    |
| Administration:         | Follow instructions in package insert. Never administer intravenously. |    |
| Supplied:               | Vials, 2 cc.   |    |

### COMBINATION PRODUCTS

|                        |  |    |
|------------------------|--|----|
| <b>HYCOTUSS</b>        | Antitussive  | Rx |
| Manufacturer:          | Endo Laboratories, Inc.  |    |
| Composition:           | Hydrocodone bitartrate 5 mg.<br>Glyceryl guaiacolate 100 mg.<br>Alcohol 10% v/v  |    |
| Indications:           | Symptomatic relief of coughs.  |    |
| Precautions:           | Same as those for other oral narcotic containing medications.                    |    |
| Dosage:                | Teaspoonful of Syrup Maximum Initial Single Dose                                 |    |
| Adults                 | 1  | 3  |
| Children over 12 years | 1  | 2  |
| 2 to 12 years          | ½  | 1  |
| Under 2 years          |  |    |
| Supplied:              | Calculate dose as hydrocodone, 0.3 mg/kg. 24 hrs, divided into four equal doses. |    |
|                        | Syrup, bottles 1 pt.   |    |

|                     |   |    |
|---------------------|---|----|
| <b>RESPERPAZIDE</b> | Hypotensive   | Rx |
| Manufacturer:       | McNeil Laboratories, Inc.   |    |
| Composition:        | Hydrochlorothiazide Reserpine 25 mg. 0.1 mg.<br>50 mg. 0.1 mg.  |    |
| Indications:        | Hypertension, not for initial therapy   |    |
| Warnings:           | The usual precautions should be followed applicable to the two ingredients.                             |    |
| Dosage:             | One tablet (25 or 50 mg. hydrochlorothiazide) one to four times daily, titrated to response of patient. |    |
| Supplied:           | Tablets   |    |

|                |   |        |
|----------------|---|--------|
| <b>TURICUM</b> | Laxative  | o.t.c. |
| Manufacturer:  | A. H. Robins  |        |
| Composition:   | Teaspoonsful contains:<br>Sod. Carboxymethyl-cellulose 0.36 Gm.<br>Magnesium Hydroxide 0.60 Gm. |        |
| Indications:   | Constipation  |        |
| Warnings:      | Do not use in nausea, vomiting or abdominal pain which may indicate appendicitis.               |        |

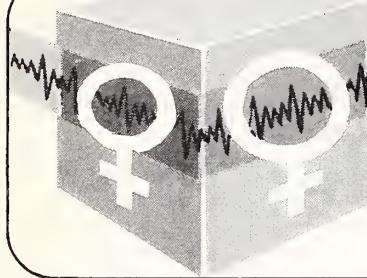
|                        |   |                         |  |
|------------------------|---|-------------------------|--|
| Dosage:                | Adults: 1 or 2 tablespoonsful at bedtime, followed by a full glass of water.<br>Children: 1 or 2 teaspoonsful according to age, followed by a full glass of water.  | Indications:            | Adjunctive therapy of acne.  |
| Supplied:              | 1 pt. bottles   | Administration:         | Shampoo affected areas.  |
|                        |   | Supplied:               | Tubes, 4 oz.   |
| <b>LIQUIX C III</b>    | <b>Analgesic</b> Rx<br>Paul B. Elder Company<br>Composition:<br>Acetaminophen 320 mg.<br>Codeine phosphate 32 mg.<br>Indications:<br>Moderate to severe acute and chronic pain.   | <b>NEW DOSAGE FORMS</b> |  |
| Dosage:                | Adults, one to two capsules q.i.d. as required.   | <b>ALUPENT Tablets</b>  | Bronchodilator Rx<br>Boehringer Ingelheim Ltd.   |
| Supplied:              | Capsules  | Manufacturer:           | Metaproterenol Sulfate   |
| <b>LIQUIX C V</b>      | <b>Analgesic and antipyretic</b> Rx<br>Paul B. Elder Company<br>Composition:<br>5 cc. contains<br>Acetaminophen 120 mg.<br>Codeine phosphate 8 mg.<br>Diseases accompanied by discomfort and fever, common cold and viral infections.   | Nonproprietary Name:    | Bronchial asthma and reversible bronchospasm   |
| Indications:           | Adults and children over 12 years, 2 teaspoonsful three or four times daily.<br>Children 6 to 12, 1 teaspoonful three times daily.  | Indications:            | Cardiac arrhythmia with tachycardia  |
| Dosage:                | Liquid  | Contraindications:      | See package insert   |
| Supplied:              |   | Caution:                | 20 mg. t.i.d. or q.i.d., not recommended in children under 12 yrs. of age.                     |
| <b>METHENEX</b>        | <b>Narcotic Antagonist</b> Rx<br>Bristol Laboratories<br>Composition:<br>Powder<br><i>Methadone HCl</i> 10 mg.<br>40 mg.<br>Effervescent Tablets<br><i>Naloxone HCl</i> 0.5 mg.<br>2.0 mg.  | Supplied:               | Tablets, 20 mg.  |
| Indications:           | Therapy of narcotic addiction and maintenance therapy   | <b>AMERICAINE</b>       | Anesthetic Lubricant Rx  |
| Warnings:              | For oral therapy only, must not be injected.  | Manufacturer:           | Arnar-Stone Laboratories, Inc.   |
| Contraindications:     | See package insert.   | Composition:            | Benzocaine 20%<br>Benzethonium Chloride 0.1%   |
| Distribution:          | Hospital pharmacies and methadone maintenance treatment programs.   | Indications:            | Lubricant and topical anesthetic on intracheal catheters, sigmoidoscopes, and vaginal specula. |
| <b>PANOXYL Shampoo</b> | <b>Dermatological Preparation</b> Rx<br>Stiefel Laboratories, Inc.<br>Composition:<br>REGULAR STRONG<br>1.5% 2.5%<br>6% 6%<br>Benzoyl peroxide<br>Polyoxyethylene lauryl ether<br>Sodium lauryl sulfate<br>Magnesium aluminum silicate<br>Hydroxypropylmethylcellulose<br>Citric acid | Directions:             | Apply evenly to exterior tube or instrument.   |
|                        |   | Supplied:               | Foil Pack, 2.5 Gm.   |
|                        |   | <b>BASALJEL</b>         | Antacid o.t.c.<br>Wyeth Laboratories   |
|                        |   | Manufacturer:           | Aluminum hydroxide   |
|                        |   | Nonproprietary Name:    | Low phosphate diet to prevent formation of phosphatic urinary stones.                          |
|                        |   | Indications:            | 2 to 6 capsules or tablets 1 hr. p.c. & at h.s.  |
|                        |   | Dosage:                 | Capsules or tablets, 500 mg. ▲   |
|                        |   | Supplied:               |  |

## Renal Cysts

(Continued from page 531)

### Summary

On the basis of the data presented in this study, it is suggested that, as a rule, simple renal cysts are asymptomatic, do not cause hematuria, are rarely palpable, and are discovered radiographically as an incidental finding. Surgical exploration is indicated only in those instances when the radiologic diagnosis of cyst is equivocal or when certain clinical criteria are present. ▲



*pulse...* of the doctor's wife

Mrs. HAROLD KEEGAN, Editor

## *40 Year Celebration For Bureau County Medical Auxiliary*



Commemorating the 40th year of the Woman's Auxiliary to the Bureau County Medical Society on September 24, 1974, were, first row (left to right): Mrs. Louis Lukansic, Spring Valley, Vice President of Bureau County Auxiliary and Mrs. Thomas Gatter, Rockford, WA/ISMS President.

Second row: Mrs. Florence Miltenberger,\* Spring Valley; Mrs. O. B. Giltner,\* Sheffield; Mrs. Louis Nix Saunders,\* Princeton, WA/ISMS past president; and Mrs. C. A. Smart,\* Granville.

Third row: Mrs. Louis Tarsinos, Princeton, President of Bureau County Auxiliary; Mrs. J. J. Nora, Tiskilwa; Mrs. J. H. Hopkins,\* Walnut; Mrs. R. E. Davies,\* Spring Valley; Mrs. C. J. Green,\* Ladd; Mrs. Louis Foley, Princeton; Mrs. John Hubbard, Sterling, WA/ISMS District 2 Councilor and Mrs. Eugene Vickery, Lena, WA/ISMS President-Elect.

\*Indicates charter member.

# Our Three State Board Directors



Mrs. Robert Hartman

Bea Hartman is our immediate past State Auxiliary President. She is now serving on the State Board as a Director. Bea is, and has been very busy for the last several years. She has served on the Jackson County level as president, recording-secretary and archives and on the State level

as chairman of members-at-large, chairman of community health, president-elect and president.

Even with all this Bea has been director of Girl Scouts Council for 8 years, is active in the church, garden club, Mayor's committee on the Arts, DAR, PEO and involved with Illinois College thru her husband's association as Trustee and secretary.

Bea and Robert, an obstetrician-gynecologist, Second Vice-President of ISMS and Chairman of HASP committee, have two daughters. One daughter is married, has 3 children and lives in Washington, D.C. and the other daughter is a French teacher with a M.S. from Purdue.



Mrs. Paul David

Rose and Paul David emigrated to the United States in 1951. Her husband is a board certified psychiatrist, Chairman of the Department of Psychiatry at Christ Community Hospital, and Assistant Professor of Psychiatry at Chicago Medical

School. Their son Raymond is working on his M.S. in Biology at Loyola and his wife is a speech therapist.

On the County level Rose is member of the Southern Cook County Branch and has served as benevolence chairman, ways and means, program chairman and president. Thru the Cook County Auxiliary as clinical conference co-chairman and chairman, community service, international health, mental health, membership chairman, president and director.

On the State Auxiliary Board she has served as 3rd District Councilor, hospitality, nominating, corresponding secretary and now as a Director.

Rose loves secretarial work and bookkeeping and helps her husband with his business. She also finds time for hospital Auxiliaries, church activities and some bridge.

**Pat Failor**, a member of the Champaign County Auxiliary is our 3rd Director on the State Board. Pat, who's husband is an internist at Carle Clinic in Urbana, is a former Speech and English teacher with degrees from the University of Chicago and the University of Wisconsin. She is very active in her community as immediate past president of the Junior League of Champaign, book review club, Champaign social service club, symphony board, secretary of YMCA board and church activities.

Pat has been her county's president and program chairman and on the State level she has been chairman of publicity for four years. She also was chairman of Women's program for the ISMS sponsored Washington, D.C., Round-up.

The Failor's have two children, Bruce a freshman in college and Kathy a sophomore in high school.

\* \* \*

## BITS AND PIECES

### —from around the Counties

**ST. CLAIR COUNTY**—Auxilians are selling special monogrammed shoulder purses to benefit AMA-ERF. Their goal is "an AMA-ERF PURSE ON THE SHOULDER OF EVERY FEMALE IN ST. CLAIR COUNTY."

**MCLEAN COUNTY**—Auxilians had a very successful rummage sale which benefits health career scholarships and community projects.

**KANKAKEE COUNTY**—Auxilians delivered two trunk-loads of groceries to Threshold Drug Rehabilitation Center. These were collected at an election day coffee.

**STEPHENSON COUNTY**—Auxilians published a Directory of agencies and organizations that may assist people who need help. Also they established an advocacy program for a number of juvenile girls.

**PEORIA COUNTY**—Auxilians and their husbands held a progressive dinner party, a fun mixer, to benefit AMA-ERF.

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
360 No. Michigan Ave. • Chicago, IL 60601 • (312) 782-1654



*Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.*

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## January, 1975

### Basic Science

#### NEW & PROPOSED CLINICAL CHEMICAL TESTS

For: MDs, paramedics, etc. Wkly. Seminar, Jan. 21, Elmhurst. Speaker: E. Winkler, Ph.D. CME Credit: 1 hr., AMA Cat. 1. Sponsor, contact: Memorial Hosp. of DuPage County, Avon & Schiller, Elmhurst, IL 60126.

### Blood Gases

#### BLOOD GASES

For: MDs & Nurses. Lecture, Jan. 22, 11:00 am, Chgo. Speaker: D. Gracey, MD, Asst. Prof. Med., Northwestern U. CME Credit: 1 hr., AMA Cat. 1. Sponsor, contact: F. Lopez-Fernandez, MD, Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chicago 60618. Co-sponsor: Chgo. Lung Assn.

### Cancer

#### CURRENT CONCEPTS IN CANCER CHEMOTHERAPY & IMMUNOTHERAPY

For: All physicians. Short course, Jan. 15, Indianapolis. CME Credit: 6 hrs., AAFP, AMA Category 1. Fee: \$35. Sponsor, contact: Postgrad. Med. Educ., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis 46202.

### Endocrinology

#### ADVANCES IN ENDOCRINOLOGY

For: All physicians. Frontiers of Medicine Lecture, Jan. 8, Billings Hospital, Chicago. CME Credit: 3 hrs., AAFP, AMA Category 1. Fee: \$20. Sponsor, contact: Frontiers of Med., Univ. of Chicago, Box 451, 950 E. 59th St., Chicago, IL 60637.

### Family Medicine

#### FIBEROPTIC COLONOSCOPY

For: All Physicians. 3-day Course, Jan. 22-24, Chicago. CME Credit: 19 hrs., AMA Category 1. Fee: \$250. Reg. Limit: 10. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood, Chicago 60612.

#### MANAGEMENT OF COMMON PSYCHIATRIC PROBLEMS

For: All Physicians. Lecture, Jan. 21, 7:30 PM, Sherman Hosp., Elgin. CME Credit: 2 hrs., AMA Category 1. Speaker: T. G. Esau, M.D., Lutheran General Hosp., Park Ridge, IL. Sponsor, contact: CME Committee, Sherman Hosp., 934 Center, Elgin, IL 60120.

### General Medicine

#### TREATMENT & DIAGNOSIS OF THYROID DISORDERS

For: All Physicians. Grp. Discussion & Lectures, Jan. 17, 10:00 AM, Bethesda Hosp.; Jan. 17, 6:00 PM, Lincolnwood Hyatt House; Jan. 18, 10:00 AM, S. R. Forkosh Hosp., Chicago. Speaker: C. A. Gorman, MD., Mayo Clinic. CME Credit: 5 hrs., AAFP. Sponsor, contact: Neil Glass, Bethesda Hosp., 2451 W. Howard, Chicago 60645, (312) 761-6000.

**GENERAL MEDICINE LECTURE SERIES—PART II**  
For: House Staff & General Staff. Weekly Lecture Series, Jan. 7, 14, 21, & 28, St. Mary of Nazareth, Chicago. CME Credit: 18 hrs., AAFP Elective. Sponsor, contact: Anthony Sapienza, M.D., St. Mary of Nazareth Hosp., 1120 N. Leavitt, Chicago 60622.

### Infectious Diseases

#### URINARY TRACT INFECTIONS

For: MDs, paramedics, etc. Wkly. Seminar, Jan. 14, Elmhurst. Speaker: B. Reisberg, MD. CME Credit: 1 hr., AMA Cat. 1. Sponsor, contact: J. H. Huss, MD, Med. Dir., Memorial Hosp. of DuPage County, Avon & Schiller, Elmhurst, IL 60126.

### Internal Medicine

#### UPPER GASTROINTESTINAL ENDOSCOPY

For: Gastroenterologists. 10-day course, Jan. 13-25, Chgo. CME Credit: 40 hrs., AMA Cat. 1., Fee: \$350. Reg. Limit: 4. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chgo. 60612.

#### Medical Education Programs

#### GOVERNMENTAL & SOCIETAL PRESSURES FOR CME PROGRAMS

For: MDs & Nurses. Lecture, Jan. 29, 11:00 am, Chgo. Speaker: C. H. W. Rube, MD, Dir., Div./Med. Ed. CME Credit: 1 hr., AMA Cat. 1, AAFP Prescribed. Sponsor, contact: F. Lopez-Fernandez, MD, Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chicago 60618.

#### Mobile Coronary Care Units

For: All MDs. Symposium, Jan. 15, Elmhurst Country Club, Wood Dale Road, Wood Dale, IL. CME Credit: 2 hrs., AMA Cat. 1, AAFP. Sponsor, contact: Mrs. L. Widmer, Exec. Sec., DuPage County Med. Soc., 646 Roosevelt Rd., Glen Ellyn, IL 60137.

#### Obstetrics & Gynecology

#### OFFICE GYNECOLOGY

For: General Practice & Part Time Specialty. 5-day Course, Jan. 20-24, Chicago. CME Credit: 32½ hrs., AMA Category 1. Fee: \$175. Reg. Limit: 80. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood, Chicago 60612.

#### Ophthalmology

#### OCULAR HISTOPLASMOSIS

For: Specialists. 2-day workshop, Jan. 30-31, Airport Hotel, Indianapolis. CME Credit: 14 hrs., AAFP, AMA Category 1. Fee: \$200. Sponsor, contact: Postgrad. Med. Educ., Indiana Univ. Sch. of Med., 1100 W. Michigan, Indianapolis, IN 46202.

#### Pharmacology

#### CLINICAL PHARMACOLOGY IN CONGESTIVE HEART FAILURE

For: All Physicians & Nurses. Lecture, Jan. 19, 11:00 AM, Chicago. Speaker: A. Brest, M.D., Jefferson Med. College, Philadelphia. CME Credit: 1 hr., AMA Category 1, AAFP Prescribed. Reg. Limit: 106. Sponsor, contact: Martha Washington Hosp., 4055 N. Western, Chicago 60618.

#### Porphyria

For: MDs & Nurses. Lecture, Jan. 15, 11:00 am, Chgo. Speaker: H. A. Peters, MD, Prof./Med., U. of Wis. CME Credit: 1 hr. AMA Cat. 1, AAFP Prescribed. Sponsor, contact: F. Lopez-Fernandez, MD, Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chgo. 60618.

#### Psychiatry

**MUTUAL RESPECT APPROACH TO CHILD GUIDANCE**  
For: Pediatricians. Monthly Mtg., Jan. 21, John Hancock Bldg., N. Mich. Ave., Chgo. Fee: Dinner Reservations, \$12; social hr., 6:00 pm, dinner 7:00 pm, program 8:00 pm. Sponsor: Chgo. Pediatric Soc. Contact: L. Zollar, MD, 121 W. 154th St., Harvey, IL 60426.

#### CURRENT & FUTURE PERSPECTIVES IN TREATMENT EVALUATION

For: All physicians. Lecture, Jan. 15, 7:30 PM, Des Plaines, IL. Speaker: T. Kiresuk, Ph.D., Minneapolis. Fee: \$15 (\$5 students). Sponsor, contact: Forest Hospital, 555 Wilson Lane, Des Plaines, IL 60616; (312) 827-8811.

### Surgery

#### TREATMENT OF CEREBRAL ISCHEMIA WITH MICROVASCULAR SURGERY

For: MDs, paramedics, etc. Wkly. Seminar, Jan. 28, Elmhurst. Speaker: R. Strzyz, MD. CME Credit: 1 hr., AMA Cat. 1. Sponsor, contact: J. Huss, MD, Dir./Med. Ed., Memorial Hosp. of DuPage County, Avon & Schiller, Elmhurst, IL 60126.

#### NEW CONCEPTS IN TRANSPLANTATION

For: MDs, paramedics, etc., Wkly. Seminar, Jan. 7, Elmhurst. Speaker: Barry Kahan, MD. CME Credit: 1 hr., AMA Cat. 1. Sponsor, contact: J. Huss, MD, Dir./Med. Ed., Memorial Hosp. of DuPage County, Avon & Schiller, Elmhurst, IL 60126.

#### FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY

For: Surgeons. 3-day Course, Jan. 27-29, Chicago. CME Credit: 19½ hrs., AMA Category 1. Fee: \$250. Reg. Limit: 10. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood, Chicago 60612.

## February, 1975

### Cardiology

#### EKG DIAGNOSIS

For: Physicians—Gen. Interest. 3-day Workshop Course, Feb. 18-20, U. of Mich., Ann Arbor. CME Credit: 21 hrs., AMA Category 1, AAFP Elective, AOA Elective. Fee: \$120. Sponsor: Am. College of Emergency Physicians. Contact: Robt. K. Richards, Director, Office of Intramural Education, Towsley Center, U. of Mich., Ann Arbor, MI 48104.

### Emergency Medicine

#### EMERGENCY MEDICINE

For: Emergency Physicians. 4-day Workshop Course, Feb. 25-28, 8:00 AM-5:00 PM, Ann Arbor. CME Credit: 28 hrs., AMA Category 1, AAFP Elective, AOA Elective. Fee: \$150. Sponsor: Am. College of Emergency Physicians. Contact: Robt. K. Richards, Director, Office of Intramural Education, Towsley Center, U. of Mich., Ann Arbor, MI 48104.

### Family Medicine

#### MEDICAL-LAW ASPECTS OF MEDICINE

For: Physicians. Lecture, Feb. 18, 7:30 PM, Elgin, IL. CME Credit: 2 hrs., AMA Category 1. Sponsor, contact: CME Committee of Sherman Hosp., 934 Center, Elgin, IL 60120.

### Gastroenterology

#### PRACTICAL EXPERIENCES IN GASTROINTESTINAL ENDOSCOPY

For: Physicians and G.I. Assistants. Combined phys.-G.I. asst. 1st day, separate Seminars and Wkshps., 2nd day. Feb. 21-22, Playboy Club, Lake Geneva, WI. CME Credit: 14 hrs., AAFP. Fees: \$200 (Phys.), \$75 (G.I. asst.). Deadline: Feb. 18. Sponsor, contact: The Medical College of Wis., 561 N. 15th, Milwaukee, WI 53233.

### Internal Medicine

#### NEW DEVELOPMENT IN DIAGNOSIS AND MANAGEMENT OF LIVER DISEASES

For: All Physicians. Feb. 12, Chicago. CME Credit: 6 hrs., AMA Category 1, AAFP. Fee: \$30. Sponsor, contact: U. of Chicago, Frontiers of Med., 950 E. 59th, Box 451, Chicago 60637.

**MALABSORPTION SYNDROME**

For: MDs & Nurses. Lecture, Feb. 26, 11:00 am, Chgo. CME Credit: 1 hr., AMA Cat. 1, AAFP Prescribed. Sponsor, contact: F. Lopez-Fernandez, MD, Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chicago, 60618. Co-sponsor: Eaton Lab.

**Obstetrics & Gynecology****GYNECOLOGICAL LAPAROSCOPY**

For: Gynecologists and Obstetricians. 3-day Course, Feb. 5-7, Chicago. CME Credit: 18 hrs., AMA Category 1. Fee: \$250. Reg. Limit: 8. Sponsor, contact: Cook County Sch. of Med., 707 S. Wood, Chicago 60612.

**Pathology**

**AGING AND MALIGNANCY OF THE ORAL MUCOSA**  
For: Dentists, Physicians, Pathologists. Symposium, Feb. 5-7, 8:30 AM-12:30 PM, Camino Real Hotel, Mexico City, Mexico. Co-sponsor: Mexico Dental Society. Speaker: P. D. Toto, D.D.S., Orban-Loyola Memorial. Fee: \$50. Reg. Limit: 100. Deadline: Jan. 1. Sponsor, contact: P. D. Toto, D. S. or A. W. Gargiulo, D.D.S., Orban-Loyola Memorial, 2160 S. First, Maywood, IL 60153.

**Pediatrics**

**SPECIALTY REVIEW COURSE IN PEDIATRIC SURGERY**  
For: Pediatricians. 5-day Course, Feb. 17-21, Chicago. CME Credit: 38 hrs., AMA Category 1. Fee: \$200. Reg. Limit: 85. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood, Chicago 60612.

**(No Title Available)**

For: Pediatricians & Physicians. Monthly Meeting, Feb. 18, Dinner 7:00 PM, Program 8:00 PM, Sheraton-Blackstone Hotel, Chicago. Fee: \$12.00 (dinner). Co-sponsor: Institute of Medicine of Chicago. Sponsor, contact: L. M. Zollar, M.D., Chicago Pediatric Society, 121 West 154th, Harvey, IL 60426.

**Pharmacology****CLINICAL PHARMACOLOGY IN CONGESTIVE****HEART FAILURE**

For: MDs & Nurses. Lecture, Feb. 19, 11:00 am, Chgo. Speaker: A. Brest, MD, Prof./Med., Jefferson Med. College, Phila., Pa. CME Credit: 1 hr., AMA Cat. 1, AAFP Prescribed. Sponsor, contact: F. Lopez-Fernandez, MD, Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chgo. 60618. Co-sponsor: Am. Soc. for Clinical Pharmacology & Therapeutics.

**Psychiatry****CURRENT AND FUTURE PERSPECTIVES IN BEHAVIOR MODIFICATION**

For: Psychiatrists. Lecture, Feb. 19, Forest Hosp., Des Plaines, IL. Speaker: I. Goldiamond, Ph.D., U. of Chicago. Fee: \$15 (Student rate: \$5). Sponsor: Forest Hosp., 555 Wilson Ln., Des Plaines, IL 60016. Contact: June Bengtsen, PR Dept. (312) 827-8811, X362.

**Surgery****GASTRIC & DUODENAL ULCERS—****SURGICAL APPROACH**

For: MDs. Grp. Discussion, Lecture, Grp. Discussion, Feb. 21, 10:00 am, S. R. Forkosh Hosp.; 6:00 pm, Lincolnwood Hyatt House; Feb. 22, 10:00 am, Bethany Methodist Hosp. CME Credit: 5 hrs., AAFP. Fee: \$10 (other than staff for dinner). Sponsor contact: P. Thorek, MD, Chm., FAB/CME, 850 W. Irving Pk. Rd., Chgo. 60613.

**MEDICAL AND SURGICAL ASPECTS OF ISCHEMIC HEART DISEASE**

For: MDs. Symposium, Feb. 19, Itasca County Club, Itasca, IL. CME Credit: 3 hrs., AMA Cat. 1, AAFP. Reg. Deadline: Feb. 17. Sponsor, contact: Ms. L. Widmer, Exec. Sec., DuPage County Med. Soc., 646 Roosevelt Rd., Glen Ellyn, IL 60137.

**SPECIALTY REVIEW COURSE IN PEDIATRIC SURGERY**  
For: Pediatric Surgeons. 5-day Course, Feb. 17-21, Chicago. CME Credit: 38 hrs., AMA Category 1. Fee: \$200. Reg. Limit: 150. Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood, Chicago 60612.

**March, 1975**

**Alcoholism****ALCOHOLISM**

For: MDs. Lecture, March 4, Chgo. Speaker: S. Nieder, MD, Dir./Alcoholic Treatment Unit, Martha Washington Hosp. Sponsor: Chgo. Med. Soc., N. Shore Branch. Contact: F. Lopez-Fernandez, MD, Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chicago 60618.

**Anesthesia**

**ELECTROCARDIOGRAPHY FOR ANESTHESIOLOGISTS**  
For: MDs. 5-day Course, March 3-7, Chgo. CME Credit: 35 hrs., AMA Cat. 1. Fee: \$200. Sponsor, contact: Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

**MEDICINE FOR TODAY—Spring Sessions**

**For:** All practicing physicians, house staff. IAFP's 26th Annual Lecture Series, with A-V and Q&A supplement. Emphasis on Orthopedics, Psychiatry, Endocrinology, & Pulmonary Function. CME Credit: 30 hrs. (maximum, for Fall, 1974, & Spring 1975 sessions) AAFP Prescribe, AMA Category 1. Fee: \$90 AAFP mbrs., \$100 non-mbrs. Meets in these cities on dates noted:

**Belleville**—Feb. 13, 20, 27, Mar. 6, 13, 20.

**Berwyn**—Feb. 12, 19, 26, Mar. 5, 12, 19.

**Centralia**—Feb. 19, Mar. 5, 19.

**Champaign**—Feb. 13, 27, Mar. 13.

**Chicago Nearwest**—Feb. 12, 19, 26, Mar. 5, 12, 19.

**Chicago North**—Feb. 12, 19, 26, Mar. 5, 12, 19.

**Chicago Southwest**—Feb. 12, 19, 26, Mar. 5, 12, 19.

**Harvey**—Feb. 12, 19, 26, Mar. 5, 12, 19.

**Hinsdale**—Feb. 12, 26, Mar. 12.

**Melrose Park**—Feb. 12, 19, 26, Mar. 5, 12, 19.

**Park Ridge**—Feb. 12, 19, 26, Mar. 5, 12, 19.

**Peoria**—Feb. 13, 27, Mar. 13.

**Rockford**—Feb. 13, 20, 27, Mar. 6, 13, 20.

**Rock Island**—Feb. 13, 27, Mar. 13.

**Springfield**—Feb. 20, Mar. 6.

For details of time and place, contact: Ill. Academy Family Phys., 14 E. Jackson Blvd., Suite 1532, Chicago, IL 60604.

**REGIONAL ANESTHESIA & THERAPEUTIC NERVE BLOCKING**

For: MDs. 5-day Course, March 10-14, Chgo. CME Credit: 40 hrs., AMA Cat. 1. Fee: \$300. Sponsor, contact: Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

**Bronchoesophagology****COURSE IN LARYNGOLOGY AND BRONCHOESOPHAGOLOGY**

For: Residents or MDs of Otolaryngology. 6-day Course, Chgo. Speaker: P. Holinger, MD, Dir./Otolaryngology. CME Credit: 45 hrs., AMA Cat. 2. Fee: \$300. Reg. Limit: 20. Sponsor, contact: Ms. W. Wickland, Adm. Sec., Dept./Otolaryngology, U. of IL, 1855 W. Taylor St., Chgo. 60612.

**Family Medicine****BASIC ELECTROCARDIOGRAPHY**

For: All MDs. 5-day Course, March 3-7, Chgo. CME Credit: 35 hrs., AMA Cat. 1. Fee: \$200. Reg. Limit: 35. Sponsor, contact: Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

**BASIC INTERNAL MEDICINE**

For: All MDs. 5-day Course, March 17-21, Chgo. CME Credit: 40 hrs., AMA Cat. 1. Fee: \$175. Reg. Limit: 50. Sponsor, contact: Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

**Geriatrics****RECENT ADVANCES IN GERIATRIC MEDICINE**

For: All MDs. 1-day Course, March 8, Chgo. CME Credit: 8 hrs., AMA Cat. 1. Fee: \$50. Reg. Limit: 80. Sponsor, contact: Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

**RECENT ADVANCES IN GLOMERULONEPHRITIS**

For: MDs & Nurses. 4th Annual Lecture, March 12, 11:00 am, Chgo. Speaker: D. Earle, MD, Prof./Med., Northwestern Medical Sch. CME Credit: 1 hr., AMA Cat. 1, AAFP Prescribed. Sponsor, contact: F. Lopez-Fernandez, MD, Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chgo. 60618.

**Internal Medicine****BASIC ELECTROCARDIOGRAPHY**

For: MDs. 5-day Course, March 3-7, Chgo. CME Credit: 35 hrs., AMA Cat. 1. Fee: \$200. Reg. Limit: 707 S. Wood St., Chgo. 60612.

**Neurology****NEUROLOGY, PART I, BASIC**

For: All MDs. 5½-day Course, March 17-22, Chgo. CME Credit: 44 hrs., AMA Cat. 1. Fee: \$200. Reg. Limit: 80. Sponsor, contact: Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

**REVIEW COURSE IN NEUROPATHOLOGY**

For: Neurologists. 5½-day Course, March 10-15, Chgo. CME Credit: 40 hrs., AMA Cat. 1. Fee: \$225. Reg. Limit: 30. Sponsor, contact: Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

**Neuromuscular Disease****NEUROMUSCULAR DISEASE: CURRENT IDEAS IN DIAGNOSIS AND MANAGEMENT**

For: All MDs. Second Wednesday of Month, March 12, Chgo. CME Credit: 3 hrs., AMA Cat. 1, AAFP. Fee: \$20. Sponsor, contact: Ms. E. Ehrman, Adm. Asst., U. of Chgo., Frontiers of Med., 950 E. 59th St., Box 451, Chgo. 60637.

**Neurotology****NEUROTOLOGY**

For: Residents or MDs of Otolaryngology. 4-day Course, March 24-27, 9:00-5:00, Chgo. CME Credit: 25 hrs., AMA Cat. 2. Speaker: N. Tokor, MD, Prof. of Otolaryngology, Dir. of Course. Sponsor, contact: Ms. W. Wickland, Adm. Sec., Dept./Otolaryngology, U. of IL, 1855 W. Taylor St., Chgo. 60612.

**Ophthalmology****ANNUAL OPHTHALMOLOGY ALUMNI DAY, U. OF CHGO. DEPT. OF OPHTHALMOLOGY**

For: Ophthalmologists. Day-long Lecture, March 5, Chgo. Sponsor, contact: J. T. Ernest, MD, Assoc. Prof./Ophth., U. of Chgo. Dept. of Ophthalmology, 950 E. 59th St., Chgo. 60637.

**Pathology****REVIEW COURSE IN NEUROPATHOLOGY**

For: Neuropathologists. 5½-day Course, March 10-15, Chgo. CME Credit: 40 hrs., AMA Cat. 1. Fee: \$225. Reg. Limit: 20. Sponsor, contact: Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

**Psychiatry****NEUROLOGY, PART I, BASIC**

For: MDs and Psychiatrists. 5½-day Course, March 17-22, Chgo. CME Credit: 44 hrs., AMA Cat. 1. Fee: \$200. Reg. Limit: 80. Sponsor, contact: Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

**Surgery****PEDIATRIC SURGERY**

For: Pediatricians. Monthly meeting, March 18, Highland Park Country Club, Highland Park. Ill. Fee: Dinner Reservations, \$12; social hr., 6:00 pm, dinner 7:00 pm, program, 8:00 pm. Sponsor: Chgo. Pediatric Society. Contact: L. M. Zollar, MD, 121 W. 154th St., Harvey, IL 60426.

**PRE AND POSTOPERATIVE CARE OF PATIENTS FOR SURGEONS & SURGICAL SPECIALISTS**

For: Surgeons and Surgical Specialists. 4-day Course, March 4, Chgo. CME Credit: 31½ hrs., AMA Cat. 1. Fee: \$175. Reg. Limit: 80. Sponsor, contact: Cook County Grad. Sch./Med., 707 S. Wood St., Chgo., IL 60612.

**Urology****ADVANCES IN UROLOGY**

For: Urologists. 2-day Course, March 3-4, Chgo. CME Credit: 16 hrs., AMA Cat. 1. Fee: \$80. Reg. Limit: 25. Sponsor, contact: Cook County Grad. Sch./Med., 707 S. Wood St., Chicago, IL 60612.

**NEWER UROLOGIC INSTRUMENTATION**

For: Urologists. 1-day Course, March 5, Chgo. CME Credit: 8 hrs., AMA Cat. 1. Fee: \$50. Reg. Limit: 8. Sponsor, contact: Cook County Grad. Sch./Med., 707 S. Wood St., Chicago, IL 60612.

# Personal Proficiency Testing

As reported in this *Journal* and in "Action Report," the ISMS Board of Trustees has encouraged voluntary participation in proficiency testing by physicians conducting laboratory services in their private offices. Proficiency testing has been required of private, commercial laboratories and hospital laboratories for some time. This is not required of private physicians' offices. Perhaps any proposed requirement might be eliminated, or at least postponed, if physicians voluntarily participate.

At this time, there are two approved testing services in Illinois. You can write to either or both and ask for information regarding services provided, costs, and availability.

The first of these has a specific program for physician office laboratories called PEP—Proficiency Evaluation Program, and costs \$139 per year. This is available from the College of American Pathologists, P.O. Box 2823, Chicago, Ill. 60690. Phone (312) 346-9151. Director is Sherry Janek.

The second program is that of the American Association of Bioanalysts, Proficiency Testing Service, 105 West Elizabeth Street, Suite 107, Brownsville, Texas 78520. Phone (512) 546-5315. The basic program costs \$135 per year. Director is Nickolas T. Serafy.

Due to mail delays it is suggested that you apply immediately, since the cut-off date for the

1975 program, the final date of application, generally is in mid-January.

Several states recently enacted laws requiring that physicians itemize charges for laboratory services provided patients by outside laboratories, when the charge is part of the bill for professional services. A statutory requirement for this has been deemed unnecessary by the Laboratory Services Committee, which opinion was endorsed by the Board of Trustees. The Judicial Council of the AMA "Opinions and Reports" addresses this adequately, and reproduced here are those items applicable in this matter.

*"Nothing in the Principles of Medical Ethics proscribes the submission of an itemized bill by a physician to his own patient for medical service he actually rendered to the patient."*

1. *The practice of pathology is an integral part of the practice of medicine,*
2. *All physicians should bill their patients directly, and*
3. *In exceptional cases, when it is not possible for the laboratory bill to be sent directly to the patient, the referring physician's bill to the patient should indicate the charges for laboratory services, including the name of the physician director of the laboratory, as well as the charges for his own professional services."*

James E. Habegger, M.D., Chairman  
ISMS Committee on Laboratory Services

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## EKG of the month

(Continued from page 546)

Answers: 1. B,C,D, 2. D,E

The ECG rhythm strips show second degree AV block that varies in its conduction ratio from 3:2 to 2:1 and occasionally 4:3. The PR interval remains fairly constant at 0.20 second suggesting this is a type II (Mobitz) second degree AV block. However, it was not perfectly constant in that the PR interval prolonged slightly in the second conducted beat of the 3:2 sequences (see beats 2, 5, and 7 in the first line). The PR interval did remain constant in other sequences (see beats 3 and 4 in line 4). Overall, the PR

interval was mostly constant.

Whenever two or more beats conducted to the ventricles, complete left bundle branch block developed. This shortened the R-R cycle, and thus, this represents rate related left bundle branch block. The first to last beat in line 4 is a premature ventricular beat. The problem of the intermittent change in the PR interval in some of the beats in the 3:2 and 4:3 sequences of second degree AV block could have been resolved by His bundle recordings and atrial pacing to establish the level of the block. Recordings made at 100 and 200 mm/second would also help. Type II second degree AV block is frequently associated with bundle branch block. Quinidine, pronestyl, or digitalis might make the block worse. A demand pacemaker was recommended. □

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# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.*

**CAIRO:** FP/CARD/PUL/INT. wanted. Southern Ill. town of 6,500. Several office locations available. Modern community hospital, excellent opportunity for practice, education, public and private schools, Jr. college, and leisure; fishing, hunting, boating. Large cities nearby. Financial arrangements available. Contact Collect: Harvey Pettry, Padco Community Hospital, 2020 Cedar St., Cairo 62914 (618-734-2400) (3)

**CHICAGO:** General Practitioner - full time; centrally located, with no weekends or nights; work on standards for rating disability; evaluation of medical impairment. U.S. Railroad Retirement Board, Attention: J. E. Schwartz, Chief D&H, 844 Rush Street, Chicago 60611. (1)

**CHICAGO:** General practitioners needed for medical center. Complete office facilities. Generous salary. Part-time. Contact: Mrs. E. Tyler or Mrs. S. Hicks, 100 E. Garfield, Chicago 60653 (312-285-3008) (4)

**CHICAGO:** Cermak Medical Center wants a full-time or part-time physician with a good background in Internal Medicine; Cardiology, infectious diseases. A well rounded G.P. Contact: Mr. T. Ebie, Cermak Medical Center, 10 E. Cermak Rd., Chicago 60616 (312-225-2750) (4)

**CHICAGO:** Openings for Emergency Medical Physicians in emergency medical group serving two fine Chicago hospitals. Competitive financial compensation. Contact: Dr. M. Segal, 650 W. Wrightwood Ave., Chicago 60614 (312-327-0777) (4)

**CHICAGO:** Part-time doctors wanted for Chicago near south side clinic. Hours 9:30 a.m. to 1:00 p.m. or 12:30 p.m. to 4:00 p.m. Must have Illinois License and insurance. Must keep designated hours. Salary open and commensurate. Send medical background. Physician Recruitment Program, ISMS, 360 N. Michigan Ave., Chicago 60601. (5)

**CHICAGO:** Local Medical Examiner, half-time, mornings, 5 days, M-F. Large company downtown with professional staff, modern facilities, needs Illinois licensed internist, GP, or surgeon. Salary negotiable. Excellent benefits. Call 312-431-4676 or write Room 764, 122 S. Michigan Ave., Chicago 60603. (5)

**CLINTON:** Population 8,200. Needs physician, four physicians at present. Centrally located, 25 miles from larger cities. Office facility available at present. Hospital with 44 beds, all services. Recreational facilities. Civic organizations. Good schools and churches. Contact: Robert Myers, M.D., 219 E. Main, Clinton 61727, 217-935-5022. (5)

**CREVE COEUR:** M.D. URGENTLY NEEDED as an associate in a very active practice in the Peoria area. hospitals. Family or General Practice within six miles of three hospitals. Present M.D. wishes to retire soon

and is concerned with his patients. Financial arrangements and over-all needs negotiable. Only those seriously interested in private practice can call collect 309-699-8022 or 309-699-5525 or write William Long, M.D., Creve Coeur, Ill. 60601. (2)

**GENEVA:** GP's or Internists - Outstanding area with unlimited practice opportunities needs you to grow with us. Ideal location for family living in the heartland of the Midwest. Geneva offers the charm of "new England" background - and all only 35 miles from the cultural and medical education advantages of Chicago. Contact: Peter G. Gilbert, M.D. c/o Community Hospital, Geneva 60134 (312-232-0711). (1)

**HAVANA:** Primary physicians needed. A central Illinois Community noted as a fishing and hunting paradise. 50 bed, fully accredited hospital with 25 room clinic adjacent. Guaranteed income for solo, duo or group practice serving an area population of 15,000. Contact: J. M. Dosher, Administrator, Mason District Hospital, 520 E. Franklin, Havana 62644 (309-543-4431) (3)

**JOLIET:** Pediatric psychiatrist to serve as consultant for the John F. Kennedy Diagnostic Clinic. Services include examination and evaluation of children ages 3 to 21; consultation with special education staff and teachers; consultant to classes for behavioral disorders. Contact: Mrs. S. Maxwell, Kennedy Diagnostic Clinic, 420 N. Raynor, Joliet 60435 (815-727-6431 x34) (3)

**KEITHSBURG:** Population 950—we need a doctor badly. We don't have a fancy office. A need of a doctor in three directions. 80 bed hospital—18 miles south in Aledo. Ambulance Service. Rock Island 45 miles away. Resort area on the Mississippi River. Good People . . . Contact: M. L. Stevens, Box 165, Keithsburg 61442 (309-374-2250) (3)

**MCHENRY:** Immediate opening for Internists, Pediatrician, General Surgeon and Thoracic Surgeon. Outstanding opportunity to join multi-specialty group in mid-west resort area near Chicago. Salary with incentive from day one; fringe benefits and unusually good income potential. Group building directly connected to 143 bed community hospital. Contact: E. F. Wilt, Jr., M.D., McHenry Medical Group, 1110 N. Green St., McHenry 60050 (815-385-1050) (4)

**MORRIS:** Associate wanted - internist, GP, surgeon; growing general practice near Chicago - population 9,000, lovely clean city. Large new office newly equipped. Hospital close. Attractive financially. Keep all you earn. Share office overhead only. Contact: Dr. V. L. Hicks, Bedford Plaza Center, Morris 60450 (815-942-4067). (1)

**NASHVILLE:** Board certified or eligible surgeon - must be willing to do general practice - 3,000-14,000 - 72 bed JCAH hospital - 50 miles east of St. Louis - excellent schools and churchs - outstanding area to live - assistance available - Contact: T. K. Janssen, 603 South Grand Ave., Nashville 62263 (618-327-8236)

**ODIN:** Population 1,300. New medical facilities being installed. Two shelter care homes and small towns nearby without facilities. Hospitals: Centralia twelve miles and Salem five miles, approximately sixty five miles east of St. Louis medical facilities. Recreational facilities nearby. CONTACT: Rolland Devor, Jr., P.O. Box 215, Odin 62870 (618-775-8499) (3)

**PINCKNEYVILLE:** Population 3500—serves an area of 20,000. Medical group partnership of four physicians seeking fifth member. Complete office facilities—2 blocks from fully accredited hospital. Salary one year —then partnership. Good recreational facilities near

St. Louis. Contact: C. E. Cawvey, M.D., 206 North Main St., Pinckneyville 62274 (618-357-2131) (4)

**ROLLING MEADOWS:** Population 20,000. Five physicians at present. 25 miles from Chicago. Loan available to start practice. One mile from 450 bed Northwest Community Hospital. Good office facilities for one or more Family Practitioners, Internists, Pediatricians. Nearby College. Contact: Keith G. Wurtz, M.D., 1430 N. Arlington Hts., Arlington Hts., 60004 (312-255-3313) (1)

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# Obituaries

••Boswell, Clarence, Rockford, died November 2 at the age of 84. He graduated from Northwestern University in 1914. Dr. Boswell was President of the Winnebago County Medical Society in 1924.

•Coats, Robert M., Homewood, died September 5 at the age of 71. Dr. Coast graduated from Northwestern University in 1929.

•Dawley, John, Alton, died October 3 at the age of 36. Dr. Dawley graduated from the University of Chicago.

•Fingal, Wallace, Sr., St. Louis, died September 16 at the age of 78. He graduated from Meharry Medical College in 1937. Dr. Fingal had practiced medicine in St. Louis for the past 20 years.

•Fovargue, Irwin, Tuscon, Ariz., died September 8 at the age of 86. Dr. Fovargue graduated from Chicago Medical School in 1927.

•Garrett, S., Champaign, died November 17 at the age of 74. Dr. Garrett graduated from the Johns Hopkins University of Medicine in 1925.

•Gavrilovich, George, Chicago, died September 16 at the age of 69. Dr. Gavrilovich graduated from the University of Beograd, Yugoslavia in 1935.

•Goldberg, Samuel, Chicago, died October 9 at the age of 69. He graduated from Rush Medical College in 1928. Dr. Goldberg was senior attending surgeon at Michael Reese Hospital. He also was associate clinical professor of surgery at the Chicago Medical School and associate attending surgeon at St. Joseph's Hospital.

•Hastings, Ralph, Chicago, died November 4 at the age of 66. Dr. Hastings graduated from Chicago Medical School in 1934.

•Kokorudz, Yaroslav, Chicago, died May 26 at the age of 55. Dr. Kokorudz graduated from the University of Berlin, Germany in 1945.

•Kukelow, Donald, Glen Ellyn, died November 11 at the age of 70. Dr. Kukelow graduated from Miami University in 1930.

•Kuplis, Karlis, Chicago, died September 22 at the age of 76. Dr. Kuplis graduated from Riga, Latvia in 1929.

•Lee, John, Elmwood Park, died October 30 at the age of 53. Dr. Lee graduated from Loyola University, Stritch School of Medicine in 1946.

•Lenth, Vincent, Jacksonville, died October 13 at the age of 87. He graduated from the University of Illinois in 1926. Dr. Lenth was recently honored by Northwestern University and the University of Illinois for over 50 years of medical practice.

•McNichols, William, Dixon, died November 17 at the age of 51. Dr. McNichols was a member of the American Academy of Ophthalmology and Otolaryngology. He was also secretary of Lee county medical society and past ISMS Trustee for the 2nd District.

•Nesler, Sheldon, Niles, died October 19 at the age of 34. Dr. Nesler graduated from the University of Illinois in 1965.

•Ohringer, Leonard, Chicago, died October 20 at the age of 64. Dr. Ohringer graduated from Wurtzburg Medical School, Germany in 1935. He was on the staff of Weiss Memorial Hospital.

••Patejdl, James, Oak Lawn, died October 31 at the age of 89. He graduated from Northwestern Medical School in 1911.

••Peterson, J., Valparaiso, Ind., died September 22 at the age of 86. Dr. Peterson graduate from the University of Illinois in 1919.

••Pintozzi, Carmen, Oak Park, died October 7 at the age of 76. He graduate from Loyola University Stritch Medical School in 1921. Dr. Pintozzi was on the staff of St. Francis Xavier Cabrini Hospital.

•Shafton, Arthur, Chicago, died October 27 at the age of 70. He graduated from University of Illinois in 1931. Dr. Shafton was an emeritus staff member of Children's Memorial and St. Joseph's Hospitals.

•Smalley, Charles, Chicago, died July 12 at the age of 69. Dr. Smalley graduated from Loyola University Stritch Medical School in 1933.

•Wolff, Hilbert, Chicago, died September 30 at the age of 59. Dr. Wolff graduated from Loyola University Stritch Medical School in 1943.

•Indicates ISMS member

••Indicates ISMS member and member of the Fifty Year Club

## View Box

(Continued from page 558)

ANSWERS: *Figure 1—an ovarian cyst, benign in character; Figure 2—leiomyomas of the uterus; and Figure 3—cystoadenocarcinoma of the ovary with an irregular thick wall.*

The technique of infusion tomography of the pelvic area (following the infusion of 300 cc. of 25% Meglumine diatrizoate, tomographic cuts of the pelvic area are taken) is valuable as a pre-

operative examination which will give diagnostic information as to the nature of a pelvic mass. It depends upon the occurrence of whole body opacification (W.B.O.) which will demonstrate the various organs and masses in the abdomen as they take up contrast media. Cystic areas will demonstrate a thin wall with a radiolucent center whereas solid tumors will pick up a more diffuse opacification and will not demonstrate a thin wall. Malignancies usually show irregular thick walls with alternating cystic areas and areas of increased density where there are excrescences of tumor. ▲

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